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National Academy of Public Administration

AN AGENCY AT RISK:

AN EVALUATION OF HUMAN RESOURCES MANAGEMENT AT HCFA

A Report for the
Health Care Financing
Administration

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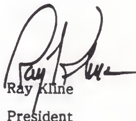
PREFACE

The debate on the cost, quality and delivery of health care in America has never been more vigorous. With health care costs escalating at a rapid rate, it is likely that health care issues will remain in the public policy spotlight for some time.

The Health Care Financing Administration (HCFA) is currently charged with the major federal responsibility for administering federal and federally assisted health care financing programs. It will have a continuing and major role in seeing that such programs are carried out effectively and efficiently and that the care provided meets acceptable standards of quality. In mandating that this study be conducted, Congress recognized that how well these programs are carried out will depend in large measure on the quality and performance of HCFA staff.

The Academy was asked to evaluate the management of human resources at HCFA. The Academy panel, made up of individuals with highly relevant expertise, found overall that HCFA is doing reasonably well the tasks it now has before it. The panel notes, however, that important changes are needed in HCFA's human resources management to prepare the agency for the increasingly complex tasks it will face in the years to come.

The Academy panel believes that implementation of the recommendations contained in this report will help ensure that HCFA will be able to continue to effectively perform its responsibilities into the future.



Ray Kline
President

LIST OF ABBREVIATIONS

AAC	Associate Administrator for Communications
AAM	Associate Administrator for Management
AAO	Associate Administrator for Operations
AAPD	Associate Administrator for Program Development
ACUS	Administrative Conference of the United States
AEP	Affirmative Employment Plan
AFGE	American Federation of Government Employees
ASPER	Assistant Secretary for Personnel Administration
BDMS	Bureau of Data Management and Strategy
BPD	Bureau of Policy Development
BPO	Bureau of Program Operations
CLIA	Clinical Laboratory Improvement Amendments of 1988
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DME	Durable Medical Equipment
DRG	Diagnosis-related Group
EEO	Equal Employment Opportunity
EOO	Equal Opportunity Office
FERS	Federal Employees Retirement System
FTE	Full Time Equivalent (Personnel)
GM	General Management
GS	General Schedule
GNP	Gross National Product
HCFA	Health Care Financing Administration
HHS	Health and Human Services (Department of)
HMO	Health Maintenance Organization
HRM	Human Resource Management
HSQB	Health Standards and Quality Bureau
MB	Medicaid Bureau

NAPA	National Academy of Public Administration
NTEU	National Treasury Employees Union
OACT	Office of the Actuary
OBA	Office of Budget and Administration
OBRA	Omnibus Budget Reconciliation Act
OCCPP	Office of Coordinated Care Policy and Planning
OHR	Office of Human Resources
OJT	On-the-job Training
OLP	Office of Legislation and Policy
OMB	Office of Management and Budget
OPHC	Office of Prepaid Health Care
OPHCOO	Office of Prepaid Health Care Operations and Oversight
OPM	Office of Personnel Management
ORD	Office of Research and Demonstrations
OTA	Office of Technology Assessment
PHS	Public Health Service
PMI	Presidential Management Intern
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Professional Review Organization
ProPAC	Prospective Payment Assessment Commission
RA	Regional Administrator
RPO	Regional Personnel Office
SES	Senior Executive Service
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

REPORT SUMMARY

The Health Care Financing Administration (HCFA) was created in 1977 through a broad reorganization of the Department of Health and Human Services (HHS). It administers Medicare and Medicaid, two large programs that finance and monitor the quality of health care for the nation's elderly, disabled, and poor. With health care costs escalating at a rapid rate, the amount and intensity of public debate focused on the health care delivery system are high. Because HCFA plays a major role in this area of growing national concern, and is responsible for programs with a great impact on the federal budget and the nation's economy, how well it accomplishes its tasks is of vital importance.

Congress registered its concern about how well HCFA's employees are able to meet the demands placed upon them when it included in the 1989 Omnibus Budget Reconciliation Act a requirement for this study. HCFA contracted with the National Academy of Public Administration (NAPA) to:

1. Study personnel administration at HCFA.
2. Assess the adequacy of HCFA staffing.
3. Recommend any needed changes with respect to HCFA staffing to the secretary of HHS and Congress.

NAPA convened a panel of experts and supporting project staff to carry out the assignment. The panel sought an understanding of HCFA's historical evolution, its mission and responsibilities, and the environment within which it must carry them out. Under panel direction, project staff used interviews, review of pertinent documentation and data, and an employee survey to learn about HCFA personnel and human resource issues as perceived by HCFA management, employees, and constituent groups.

NAPA provided HCFA with a draft of this report for review and comment on June 4, 1991. The HCFA administrator's comments to NAPA, dated September 3, 1991, appear in Appendix J.

HEALTH CARE: A MAJOR NATIONAL ISSUE

National health care expenditures have grown from 5.9 percent of gross national product (GNP) in 1965, when Medicare and Medicaid were enacted, to 12.3 percent in 1990, and are projected to reach more than 16 percent by the year 2000. Medicare benefits are projected to grow 41 percent from their fiscal year 1990 level of $98.1 billion to $138.5 billion by fiscal year 1994. The rate of cost escalation is such that the executive branch has stated that, unless policies are adopted to stem growth, soon after the turn of the century the outlays for Medicare will exceed the outlays for Social Security and defense. This would make Medicare more expensive than either of two programs that traditionally have held prominent positions in the federal budget. The federal share of the state Medicaid program costs are projected to grow more than twice as quickly as the costs for the Medicare program: federal costs are projected to grow 90 percent from $41.1 billion in fiscal year 1990 to $78.2 billion by fiscal year 1994.

Despite the rapidly increasing private and public costs, millions of Americans cannot afford adequate care: about 31 million lack insurance against acute care costs, and few are insured against long-term care costs. This circumstance has prompted proposals -- both modest and far reaching -- for changes in the way health care delivery is organized and financed, and in the way payments for care are administered. Regardless of which, if any, proposals find favor, HCFA will almost certainly continue to have the central role nationally in seeing that federal and federally assisted health care financing and quality assurance programs are effectively and efficiently carried out. With such a critical and challenging mission, it is imperative that HCFA has the institutional capacity to do the job.

HCFA'S MAJOR CHALLENGES

Most operating activities of the programs HCFA administers are carried out by others, primarily contractors and state agencies. HCFA implements governing legislation principally by:

- Establishing policy, procedures, and standards through regulation or instruction.

- Contracting (or, in the case of Medicaid, reviewing and approving state plans) for program performance.

- Overseeing and monitoring program performance.

- Applying sanctions or requiring corrective action where performance deviates from requirements or accepted norms.

HCFA's activities are highly leveraged through contractors and the states in their impact on the health care community, the beneficiary populations served, and public program costs. As such, the implications of how well HCFA carries out its activities are significant and far-reaching.

Since 1980, HCFA has had to react to numerous legislative changes and requirements affecting its programs. Many have been included in annual budget legislation, and many have had very tight deadlines for implementation. Major changes have included revising the bases on which Medicare pays for health care, expanding programs or program benefits, and strengthening the regulation of the quality of care provided under the programs. With the legislative evolution that has taken place, including the adoption of many measures to help contain escalating program costs and control the federal budget deficit, HCFA programs have become more complex and detailed. As a result, the number of areas of expertise and specialized knowledge that must reside in HCFA staff has multiplied. The staff increasingly need to have comprehensive knowledge of the many aspects of medical care and treatment and changes in related technology, and of the data and methodologies that must be employed to develop and administer ever more complex approaches to payment for care and treatment. The continuing changes have made relating HCFA's workload to required staff resource levels even more difficult than usual.

HCFA's authorized staff levels fell from about 5,000 in 1980 to a low of about 3,850 in fiscal year 1987, mostly as a result of an emphasis on reducing the size of government.

Since fiscal year 1987, staff levels have increased by about seven percent with levels authorized for fiscal year 1991 and proposed for 1992 at about 4,100. For the past several years, despite having to implement numerous important changes to its growing programs, HCFA has had a relatively fixed level of personnel resources to carry out its responsibilities.

HOW WELL IS HCFA DOING?

The panel reviewed extensive data from interviews with many individuals outside the federal government -- representatives of states and state agencies, health care providers, Medicare contractors -- as well as officials from HHS, the Office of Management and Budget (OMB), congressional committees, and HCFA. The panel also reviewed employee survey data as it bore on employee morale. The panel concluded that HCFA is meeting its difficult challenges reasonably well. Although there are clearly some shortfalls in performance, HCFA is not an agency whose programs are in serious disrepair or are failing to deliver intended benefits to the populations they are intended to serve. Nor does HCFA suffer from low staff morale. It is clear to the panel, however, that HCFA is being stretched to and perhaps beyond its present capacity by the challenges it must meet, particularly in implementing effectively a heavy and continuing workload of legislative change.

HCFA'S WORKFORCE

HCFA lacks a workforce management information system. Regular reports cover current staff only; there are no regular reports on workforce trends and no historical data readily available on fundamental matters such as numbers, grades, occupational distribution by organizational unit, accessions and attrition. No reliable data are available on the educational profile of the workforce or on staff training. Project staff requested HCFA to prepare special reports from data maintained by HHS; unfortunately, there are questions about the accuracy of the data in the reports provided, and the data must be viewed with

that qualification. The employee survey was designed to develop additional data on the workforce, including levels of educational attainment. In drawing its conclusions, the panel relied extensively on data from the survey and from interviews to augment data obtained from personnel reports. HCFA has now initiated efforts to define workforce data needs to provide the basis for designing a useful system.

Staff Changes

Over the past six years, in addition to fluctuation in staff levels, there has been a shift in the occupational mix of staff among HCFA's 12 major professional and administrative occupations. There has also been a shift away from regional offices to the central office. It appears that there has also been an increase in the number of clerical and technical employees promoted to professional and administrative positions in the past 10 years. Employee survey data indicate that more than one-third (more non-supervisory positions than supervisory, and more in the central office than in the regions) of all professional and administrative staff started their HCFA careers in clerical or technical positions. Such staffing practices apparently have been fostered by a number of employment freezes or other restrictions in HCFA and HHS over the years.

Does HCFA Have Enough Staff?

The panel primarily considered informed judgments obtained through interviews and the employee survey to gauge the adequacy of staff levels. **Allowing for some degree of bias, the panel concluded that HCFA has some degree of understaffing, probably less than 10 percent overall.** The understaffing appears to be fairly evenly distributed among all major units; no strong evidence was found that any major reallocation of staff resources is in order.

Beyond Numbers: Is Quality Present?

The panel's assessment of current staff quality is somewhat mixed. The quality of senior staff seems to be quite high. Staff below the senior level appear to have varied levels of capability although most are reasonably well-suited to their current assignments. However, the panel believes there are not enough high quality mid-level staff to provide an adequate pool of talent from which to replace the current managers and other senior staff. Also, there are indications that toleration of poor performers is having an adverse affect on the morale of other employees.

The Graying of HCFA

HCFA has a rapidly aging workforce. A substantial fraction of the staff will reach retirement eligibility by 1997, including 40 percent of HCFA's supervisors and managers. Of even greater concern is the fact that the median age of the mid-level staff, from which the future management and senior analysts would be expected to be selected, is not much different from that of the current managers and senior analysts.

Equal Employment Opportunity

Based on interview and survey data as well as the last Equal Employment Opportunity Commission review of HCFA's affirmative action program, the panel found no evidence of major equal employment opportunity problems in HCFA. One potential problem is whether HCFA can significantly improve minority and female representation at the more senior levels through promotion from within.

HCFA'S HUMAN RESOURCE MANAGEMENT PROGRAMS

In assessing HCFA's human resource management (HRM) programs, the panel relied on project staff review of documentation relating to programs in place in addition to survey

and interview data. The panel considered the HRM organizational responsibilities and the areas of recruitment, equal employment opportunity (discussed above), position classification and compensation, and training and career development programs.

Personnel functions for HCFA's central office, with about 2,500 employees in Baltimore and Washington, are carried out by its Office of Human Resources (OHR). The 10 regional offices, with about 1,600 employees, are served by HHS regional personnel offices (RPOs).

Recruitment Programs Fragmented

Recruitment, both in the central office and in the regions, is achieved largely through networking rather than through any organized recruitment program led by OHR or the RPOs. OHR provides no functional guidance to the regions or to the RPOs. HCFA has made good use of the Presidential Management Intern Program and some use of the Cooperative Education Program in recruiting staff at entry levels. Available data indicate, however, that more than two-thirds of hiring for professional and administrative positions during the past four years is at mid-career levels; i.e., above grade GS-9. The panel found mixed views from interview and employee survey data about the overall quality of recently recruited staff.

Classification and Compensation Problems

The panel also found the evidence on classification and compensation systems mixed. Given government-wide dissatisfaction with the federal position classification system, there is less dissatisfaction in HCFA than might be expected. Overall, the grade structure appears to be appropriate for HCFA, but it needs to be further examined by HCFA in some central office organizational units and OHR needs to give increased attention to classification in the regional offices. In addition, HCFA needs to give attention to classification of professional and administrative positions where a higher grade may be

warranted by the impact of the person on the position.

Training and Career Development Needs Improvement

The panel found that improved training and career development programs are a major need in HCFA. The agency has no overall career development strategy and has done little to assess training needs. As in other human resource areas, the division of responsibility between OHR and the RPOs has contributed to uneven attention to training and career development. There is need for improvement in program training, skills training, and supervisory and managerial training. There is a particular need to meet the training needs of those promoted into professional and administrative positions from clerical and technical positions. Training funds are unevenly allocated to the various units, and some units have been more aggressive in meeting the training needs of their staffs than others. Training in the use of personal computers throughout the agency reportedly has been quite good.

CONCLUSIONS AND RECOMMENDATIONS

The panel reached one overarching conclusion that forms the central theme of this report. Although HCFA is performing reasonably well, it must act now to prepare itself to meet its future human resource needs. Unless HCFA strengthens its human resource infrastructure now, its viability as an effective institution in the future will be at risk.

In the panel's judgment, failure to act will not lead to a dramatic collapse as in the somewhat analogous case of a highway bridge on which needed maintenance has been too long deferred. Rather, HCFA's responsibilities gradually will be carried out less and less effectively until the lack of organizational effectiveness is generally recognized as having reached crisis proportions. At that point, reaction will likely involve reorganizing and shifting responsibilities away from HCFA -- poor remedies for the failure to build and maintain HCFA's institutional strength and effectiveness. Because of the role HCFA plays in an area of critical importance to the American people, national interest requires that it

be a first-rate agency.

Greater Senior Management Attention Needed

To be a first-rate agency able to meet effectively its continuing and growing challenges, HCFA will need a cadre of employees who are well qualified and trained for their responsibilities and highly motivated to carry out the work of the agency. Taking steps to assure that such a workforce is in place is an extremely important responsibility of the political and career leadership of the agency. The character of the present workforce, particularly its age distribution and the likelihood that a large fraction of experienced and better educated managers, supervisors and other senior staff will be lost through retirement in the next few years, heightens the importance of this responsibility.

It is clear to the panel that this responsibility has not received the attention it deserves. Perhaps not surprisingly, with 11 administrators in 14 years, and through a period of severe fiscal constraint and very active program change, the evidence is that HRM has not been very high on the agenda of HCFA leadership. The panel believes the time has come when HCFA leadership must give HRM a very high priority. HCFA cannot effectively address the human resource issues it faces without strong and continuing policy direction and attention from senior management, beginning with the administrator but including the full executive team.

The panel recommends that a senior management official be charged with responsibility for directing, on behalf of the administrator, the development of HRM strategies and seeing to their implementation for all of HCFA. This official should be a strong leader with a demonstrated record in management and a long-term commitment to the agency. The organizational level at which this individual is placed is not as important as clearly establishing the value to be placed on the HRM function. This can be done best by the administrator through continuing interest in and commitment to the subject.

The panel believes that the specific organizational placement of this official, the specific functions of the position, and the specific relationships between the position and the rest of the HCFA organization should be determined by HCFA. The panel recommends that as a first step the administrator establish a task force broadly representative of the organization to consider, in light of this report, the specific organizational and functional issues surrounding the creation of such a position and prepare options for the administrator's consideration. The panel believes this approach will result in final decisions more likely to enjoy a high degree of organizational acceptance and more finely tuned to HCFA's needs, and thus be more likely to survive changes in top level leadership and stand the test of time.

Role of OHR Needs Redefinition

The panel recommends that the mission of the OHR be redirected to provide HRM support for the entire agency, including support for agency consideration of the long-range HRM issues discussed in this report. It will need to move from a personnel servicing orientation to one of advance planning and creativity. Such redirection is needed to complement and support the stronger senior management involvement needed in the management and development of HCFA's human resources.

Other Recommendations

The panel makes a number of other important recommendations within the report for actions supportive of HCFA's HRM needs, all to be undertaken within the framework provided by strong executive leadership and a redirected OHR. The recommendations are principally directed toward the development of the following crucial elements of a new and revitalized HRM program:

- A comprehensive and reliable workforce data base.
- A human resource planning process on a HCFA-wide basis.

- A continuing staffing and outside recruitment program to improve the age, education, and "high potential" profile of the HCFA workforce. Maintaining a viable, uninterrupted recruitment program with strong links to higher education institutions will require the cooperation of HHS, OMB, and the congressional authorization and appropriation committees.
- Expanded training and development programs, based on a sound needs assessment, with special emphasis on managerial and executive development and the needs of staff promoted from clerical or technical positions into professional or administrative positions.

Finally, to give HCFA management the resource flexibility it needs to deal with the many issues it must face, including current workload demands and requirements for strengthening the workforce potential, the panel recommends that HCFA seek authority to increase its staff levels by modest increments during the next few years. Increases of up to a total of 10 percent would appear to be reasonable. The panel recommends further that the secretary of HHS, the director of OMB, and Congress consider favorably HCFA requests for staff level increases within this range.

CHAPTER ONE
INTRODUCTION

The Health Care Financing Administration (HCFA) was created in 1977 through a broad reorganization of the Department of Health and Human Services (HHS). It administers Medicare and Medicaid, two large programs that finance and monitor the quality of health care for the nation's elderly, disabled, and poor. With health care costs escalating rapidly, the amount and intensity of public debate focused on the health care delivery system are high. Because HCFA plays a major role in this area of growing national concern and is responsible for programs of great impact on the federal budget and the nation's economy, how well it accomplishes its tasks is of vital importance. HCFA's ability to effectively administer these programs depends largely on the adequacy of the size and quality of its workforce.

CONGRESSIONAL REQUEST FOR HCFA REVIEW

In section 6233 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), entitled "HCFA Personnel Study," Congress registered its concern about how well HCFA's employees are able to meet the demands placed upon them. It required HCFA to enter into a contract with an independent evaluator to:

1. Study personnel administration at HCFA.
2. Assess the adequacy of HCFA staffing.
3. Recommend any needed changes with respect to HCFA staffing to the secretary of HHS and Congress.

The section required the study to include interviews with management officials at HCFA and other appropriate agencies and to consider issues such as:

- The average years of service, years to retirement and average age of various categories of HCFA personnel.

- The adequacy of HCFA practices to recruit personnel to replace people who retire or resign and train new employees in the intricacies of HCFA programs.

- The grade structure of various categories of HCFA personnel, and the need for additional non-supervisory positions at the GS 13, 14, and 15 levels for particularly skilled and expert personnel needed for HCFA to carry out its missions.

- Office of Personnel Management rules that may be burdensome to the hiring process.

HCFA contracted with the National Academy of Public Administration (NAPA) to conduct the independent evaluation. NAPA is a congressionally chartered non-profit organization with the mission of improving the effectiveness of federal, state and local government. NAPA works toward that end chiefly by using the individual and collective experience of its members, as practitioners and students of government, to provide expert advice and counsel to government leaders.

In response to Congress's concerns, NAPA proposed to:

1. Assess the quality of personnel administration in HCFA.

2. Assess whether or to what degree the workforce of HCFA is, in terms of numbers and skills, commensurate with the effective and timely accomplishment of the array of tasks involved in the fulfillment of HCFA's responsibilities.

3. Seek to identify and describe factors underlying problems disclosed by the study.

4. Define and recommend improvement actions that may be needed.

EVALUATION METHODOLOGY

NAPA conducts each of its studies under the guidance of a panel of accomplished experts, some of whom are elected Academy Fellows and some of whom are selected from outside the Academy membership to supplement Academy expertise. For this project, NAPA brought together the following panel:

- Laurence E. Lynn Jr.,* Chair, professor, Graduate School of Public Policy Studies and Social Services Administration, University of Chicago.
- David Bray, executive dean for administration, Harvard Medical School.
- Molly Joel Coye,* director, Division of Public Health, School of Hygiene and Public Health, Johns Hopkins University.
- Merlin K. DuVal, health consultant.
- Mary Jane England,* president, Washington Business Group on Health.
- Antonio Favino, senior vice president, Blue Cross Blue Shield of Florida.
- Sally H. Greenberg,* consultant.
- Lawrence S. Lewin, president, Lewin/ICF.
- Keith Weikel, senior executive vice president, Health Care and Retirement Corporation.

A project staff supported the panel, which met four times during the study. Biographies of the evaluation project panel members and staff are in Appendix A.

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* Academy Fellow

The panel believed that it was critical to proceed with the study by first seeking an in-depth understanding of HCFA's historical evolution, its mission and responsibilities, and the environment within which it must carry them out. Under panel guidance, NAPA project staff used documents, interviews, focus groups, a questionnaire, and personnel data to learn about the personnel and human resource issues in HCFA as perceived by HCFA management, employees, and constituent groups. In addition, the HCFA administrator and the associate administrator for management addressed the panel at their first meeting. Findings from the information gathered by the methods described below are presented throughout the report.

Interviews

The NAPA project staff conducted more than 130 interviews with officials of HCFA and HHS, and with representatives of groups who have contracts or dealings with HCFA. In order to gain an accurate understanding of how HCFA's human resources function was related to the agency's responsibilities and mission, the project staff began its investigation by conducting a round of interviews with central office staff at the bureau head level and above. In addition, project staff interviewed key staff members of HCFA's Office of Human Resources (OHR), the Assistant Secretary for Personnel Administration at HHS, and key members of his staff.

NAPA project staff visited four regional offices -- Philadelphia, Atlanta, Kansas City and San Francisco -- to secure the perspectives of regional administrators, associate regional administrators, and administrative officers. In addition, they met with the HHS regional personnel officers with responsibility for supporting HCFA's regional offices.

Project staff also conducted numerous interviews with outside groups and individuals, including health care provider organizations, state medicaid agencies, state licensure and certification agencies, fiscal intermediaries, and constituent associations, as well as staff from HHS, OMB, and congressional committees. In addition, NAPA project staff held

further interviews with HCFA staff at the office and division director level. A list of organizations and offices where project staff interviewed is in Appendix B.

Data Requests

NAPA project staff made several requests to OHR for specific workforce data. They requested information on employee education levels (when hired and currently); retirement projections of current HCFA staff; performance management ratings; turnover and hiring rates; training programs; and age, grade and occupational distributions. Because HCFA maintains inadequate information on its workforce, a problem that will be discussed in greater detail later, HCFA was able to provide only part of the information requested; additional data were obtained with the assistance of HHS and from those who responded to the employee survey, which is discussed below.

Employee Survey

With the cooperation of HCFA, the NAPA panel distributed a survey to all HCFA employees. HCFA management announced, in an accompanying cover letter, that completing the survey was mandatory, and asked employees to turn in a signed receipt to their administrative officer indicating they had completed the survey and returned it directly to NAPA. NAPA guaranteed the anonymity of respondents. More than 80 percent (3,196) of employees responded by the cut-off date, and their responses were analyzed as described below.

Those responding to the survey were representative of the workforce as a whole, with the exception of clerical workers and women, who were slightly underrepresented. The survey asked questions about demographics, education and employment history, job experiences, and job satisfaction. Supervisors had a separate section to complete including questions on supervisory training, personnel management issues, the quality of new hires, adequacy of staff levels and other issues.

The survey was analyzed in the aggregate and broken out by several groups. For almost every analysis, responses by supervisors were separated from those of non-supervisory employees. Responses by regional and central office respondents were compared, as were responses within HCFA by major organizational units and within regional offices by division. Analyses were also made of responses by those in professional and administrative occupational groups who were under age 40; had been with HCFA for fewer than five years; had begun their careers with HCFA in clerical, technical or wage grade occupations; and had entered HCFA through Presidential Management Intern or other management intern programs. In addition, survey responses were analyzed by gender, by race, and by grade bands.

The panel and project staff found few differences among the groups compared. The panel discusses in this report the few areas where important differences were found. The survey instrument, with the percentage distribution of responses to each question and a break-out of the differences between supervisory and non-supervisory responses, may be found in Appendix C.

Employees were given the opportunity to add written comments on the last page of the survey. About 45 percent (1,458) of those who responded to the survey also wrote comments. Project staff coded the comments into thirteen response categories and analyzed them by organizational units and other groupings. Appendix D contains more information on the analysis of written comments.

Focus Groups

NAPA project staff asked OHR to provide a list of employees who had been hired at HCFA's central office within the last three years. HCFA arranged for three groups of seven to ten of these employees to be brought together to discuss with NAPA project staff, in an off-the-record session, what they were looking for in an employer, what made a

potential employer attractive to them, what their HCFA hiring process had been like, and what suggestions they had to make HCFA more attractive to new recruits.

HCFA COMMENT

NAPA provided HCFA with a draft of this report for review and comment on June 4, 1991. The HCFA administrator's comments to NAPA, dated September 3, 1991, appear in Appendix J.

ORGANIZATION OF THE REPORT

Chapter One outlines the purpose and methodology of the NAPA study. Chapter Two discusses the creation of HCFA and describes its major program responsibilities. The first section of Chapter Three examines the development of HCFA, with special attention given to the forces that have changed HCFA's roles and responsibilities. The second section considers how well HCFA is doing its job, from the perspectives of those outside and inside the organization. Chapter Four evaluates the HCFA staff in terms of numbers, quality, and key demographic indicators, and relies extensively on interview and survey data for its portrayal of the workforce.

Chapter Five of the report analyzes the human resources programs at HCFA, including recruiting, equal employment opportunity, classification and compensation, and training and career development, and offers the panel's recommendations on how to strengthen many of those programs and the role of OHR in human resources management (HRM). It also addresses the relationship between HCFA and HHS in serving the regional employees. Chapter Six focuses on the need for strong HRM leadership at HCFA and the role of top management in building and maintaining a vital HRM capacity at HCFA.

CHAPTER TWO

BACKGROUND

HCFA'S ORIGINS

When HCFA was formed in March 1977, the responsibility for administering several programs from different parts of HHS was brought together into one organization. HCFA linked together Medicare, from the Social Security Administration (SSA); Medicaid, from the former Social and Rehabilitation Service (SRS); and certain health quality control functions -- notably the Professional Standards Review Organization (now the Professional Review Organization or PRO), and long-term care standards enforcement, from the Public Health Service (PHS). Subsequently, in 1986, the health maintenance organization (HMO) program was transferred to HCFA from PHS.

The administrator of HCFA reports to the secretary of HHS. There have been 11 administrators of HCFA in the 14 years since its creation, five of whom were acting administrators who served for relatively short periods from less than two months to about one year. Of the five former administrators who were appointed by the president with senate confirmation, only two served for more than two years: Carolyn Davis from March 1981 to August 1985 and William Roper from May 1986 to February 1989. The current administrator, Gail Wilensky, was appointed in February 1990.

HEALTH CARE: A MAJOR NATIONAL ISSUE

HCFA's responsibilities for financing and monitoring the quality of health care for the nation's elderly, disabled and poor give it a critical role in an area of major and increasing national importance.

Costs Claim Increasing Share of GNP; But Access Problems Persist

In 1965, the year before the Medicare and Medicaid programs became effective,

national health care expenditures were $41.6 billion and represented 5.9 percent of gross national product (GNP). By 1990, they had grown to $671 billion and 12.3 percent of GNP, amounting to more than $2,500 per capita, the highest of any nation in the world. They are projected to grow to more than 16 percent of GNP by the year 2000. The fiscal year 1991 budget submitted to Congress stated that, unless policies are implemented to stem this growth, spending on Medicare will exceed spending on Social Security retirement and defense soon after the turn of the century. This would make Medicare more expensive than either of two programs that traditionally have held prominent positions in the federal budget.

Despite these heavy and rapidly increasing costs, millions of Americans are not adequately covered; they cannot afford and are thus denied care that in most industrialized countries is treated as a routine right. Many have insufficient health insurance coverage; about 34 million Americans lack any insurance against the cost of acute care. Millions of others have coverage that provides incomplete protection against the cost of serious illness and particular risks. And few people are insured against the costs of long-term care.

Health Costs a Growing Portion of Federal Budget

Between 1970 and 1995, outlays for health programs will have grown from about 5 to about 15 percent of total federal budget outlays. The Medicare and Medicaid programs currently account for about 90 percent of these outlays and for a substantial proportion of the nation's health care expenditures. With continuing and growing pressure for budget constraint in the face of large deficits, these programs, particularly Medicare, have been and will continue to be targets for cost savings to help contain the growth of the federal budget.

Medicare

Medicare, authorized under Title XVIII of the Social Security Act, is a nationwid

health insurance program for the aged and certain disabled persons. It has two parts: Part A, hospital insurance and Part B, supplementary medical insurance.

Most citizens 65 or older are entitled to protection under Part A because they have fully insured status and are entitled to receive Social Security or railroad retirement cash benefits. Disabled persons who receive Social Security or railroad retirement disability benefits are entitled to coverage after a two-year waiting period. Most persons needing a kidney transplant or renal dialysis because of chronic kidney disease are entitled to coverage regardless of age. In fiscal year 1990, 30.0 million aged and 3.3 million disabled people had protection under Part A.

Coverage under Part B is voluntary and is partially financed by monthly premiums paid by the enrollees. All persons aged 65 or older, whether or not eligible for Part A coverage, and all persons eligible for Part A because of disability or kidney disease are eligible to enroll. In fiscal year 1990, 29.9 million aged and 3.0 million disabled Americans were enrolled in Part B.

Subject to certain limitations, deductibles, and co-insurance, Part A covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Part B covers doctor services, home health for persons not covered under Part A, and other medical and health services such as laboratory and other diagnostic tests, X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices, physical and speech therapy, and ambulance services. Benefit payments under Medicare totaled $98.1 billion in fiscal year 1990 and are projected to rise about 41 percent to $138.5 billion by fiscal year 1994.

Medicaid

Medicaid, authorized under Title XIX of the Social Security Act, is a federal-state matching entitlement program that provides medical assistance for low-income persons who are aged, blind, disabled, members of families with dependent children, and certain other

pregnant women and children. Within federal guidelines, each state designs and administers its own program; there is substantial variation among states in terms of persons covered, types and scope of benefits, and amounts of payments for services. The federal share of Medicaid program costs totaled $41.1 billion in fiscal year 1990 and is projected to rise about 90 percent to $78.2 billion by fiscal year 1994.

Quality Assurance Programs and Activities

Under both the Medicare and Medicaid programs, utilization and quality control functions are carried out in part in conjunction with the examination and processing of claims for covered services provided to beneficiaries, and in part through separate efforts. HCFA assures that institutional health care providers meet appropriate standards for program participation through periodic surveys of facilities. The surveys cover elements such as physical facilities, qualifications and levels of staff, conditions of safety and sanitation, etc. Ongoing reviews of services provided under the programs are conducted by professional review organizations (PROs). These reviews cover the necessity and reasonableness of care, the quality of care, and the appropriateness of the care setting.

Program Operating Activities

As contemplated by the legislation that governs the programs HCFA administers, it carries out few program operating activities directly:

- Medicare beneficiary intake functions, including eligibility determinations, and some beneficiary communications functions are carried out by SSA as provided for by law and under memoranda of understanding with HCFA.

- Other Medicare insurance operations are carried out primarily through contractors -- currently 50 for Part A, called "fiscal intermediaries," and 34 for Part B, called "carriers" -- who receive, review, and pay claims for covered health care and, as necessary, audit provider costs. Nine contractors serve as hosts for the relatively new common working file that brings together claims information for individual beneficiaries for control purposes.

- HCFA contracts directly with prepaid health care plans that it has qualified to participate in the Medicare program as providers of care to beneficiaries who choose to enroll in such plans; it contracts for the audit of these plans.

- Medicaid is essentially the aggregate of 56 somewhat varied programs carried out by the states and jurisdictions under federally-approved state plans, with federal financial participation and oversight.

- Utilization and quality control functions (not carried out as part of the claims receipt, review, and payment functions by Medicare fiscal intermediaries and carriers or by states and/or their fiscal agents) are carried out primarily through contract and agreement. Reviews by 53 PROs focus on the necessity and reasonableness of care, quality of care and the appropriateness of care setting for Medicare beneficiaries (and, under contract with the states and jurisdictions, Medicaid beneficiaries). Under agreement with HCFA, 53 state health facility licensure and certification agencies (state survey agencies), the Joint Commission for the Accreditation of Hospitals, and other contractors survey health care facilities to determine whether conditions for participation in the Medicare and/or Medicaid programs are met.

Fiscal year 1990 total federal outlays for Medicare benefits and payments to states for the Medicaid program were about $140 billion. In comparison, HCFA spent $1.8 billion, or about 1.3 percent of that amount, for program administration. More than 80 percent of the program administration money went to Medicare contractors ($1.4 billion), to state survey agencies ($93 million), and to finance contracts and agreements for research, demonstration and evaluation projects ($50 million). The balance of $336 million covered the remainder of HCFA's costs, including personnel compensation and benefits totaling $197 million.

HCFA is primarily engaged in implementing the governing program legislation through:

- Establishing policy, procedures, and standards through regulation or instruction.

- Contracting (or in the case of Medicaid, reviewing and approving state plans or waivers from requirements) for program performance.

- Overseeing and monitoring such performance.

- Applying sanctions or requiring corrective actions where performance deviates from requirements or accepted norms.

The activities carried out directly by HCFA deserve to be done well. They are highly leveraged through HCFA's contractors and state agencies in their impact on the health care community, the beneficiary populations served, and public program costs. As such, the implications of how well HCFA carries out its activities are significant and far-reaching. At the same time, the character of these activities makes HCFA largely a staff organization, and makes the management functions of workload measurement and relating workload to needed personnel resources highly judgmental and difficult.

Legislative Changes

Since the early 1980s, HCFA has had to react to a great number of legislative changes and requirements, many included in omnibus budget reconciliation laws, that have expanded and made even more complex the health care financing and quality assurance programs it administers. (Major legislative enactments are listed in Appendix D.)

Some of the major changes have been directed to revising the bases on which the Medicare program pays for health care:

- Prior to 1983, subject to certain limitations, Medicare reimbursed hospitals according to the reasonable costs incurred in providing services to Medicare beneficiaries. The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) called for HHS to develop proposals for the prospective payment of hospitals.

  Legislation (Public Law 98-21) based on the HHS proposal provided that, effective October 1, 1983 (with a four-year transition period), payment for most hospital inpatient care would be made under a prospective payment system (PPS), rather than a retrospective cost-based system (certain classes of costs and certain hospitals remained on the retrospective system). PPS is based on predetermined rates representing the average cost, nationwide, of treating a Medicare patient according to his or her medical condition. The rates are adjusted for certain types and locations of hospitals and adjusted annually to reflect price increases.

  As the parties involved gained experience with this major change, legislative adjustments followed in an attempt to contain costs and for other reasons.

- At present (as from the inception of Medicare), physicians are paid for services covered by Medicare on the basis of reasonable charges. Legislation included by Congress in the 1989 Omnibus Budget Reconciliation Act (OBRA 89, P.L. 101-239), which takes effect over a five-year period beginning in 1992, provides for a fee schedule that bases payments on the time, skill and intensity associated with the service rendered, rather than on historical charges. This is a major change which, with experience, will also probably require adjustment.

- Numerous legislative enactments have made changes in bases for payment and payment limitations for hospital outpatient care including renal dialysis and ambulatory surgery, outpatient care in free standing facilities, skilled nursing care, hospice care, home health care, and durable medical equipment (DME).

  For example, prior to 1983, hospital outpatient care was reimbursed on the basis of reasonable costs. Now, payments for:

  - Emergency and some other services are based on reasonable costs.

  - Outpatient dialysis are based on fixed composite rates.

  - Clinical laboratory services are based on fee schedules.

  - Ambulatory surgery are based on the weighted average of the hospitals' costs and the prevailing fee which would be paid to a free standing ambulatory surgery facility in the area.

  As another example, rental and purchase of DME used to be paid for on the basis of reasonable costs or reasonable charges, depending on the type of provider or supplier. Effective January 1, 1989, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87, P.L. 100-203) substituted a fee schedule as the basis of payment for all suppliers, established six discrete categories of DME, and specified how fee schedule amounts are to be calculated for each category.

Other major legislative changes have been directed to strengthening the regulation of the quality of certain kinds of care provided under the programs:

- OBRA 87 included provisions (nursing home reform) to upgrade the conditions of participation, survey and certification procedures, and enforcement remedies for skilled nursing facilities and intermediate care facilities, effective October 1, 1990. In addition to upgrading standards for physical facilities and staffing, the law provides more explicit requirements for staff training and a more direct focus on resident assessment and well-being.

- Currently, HCFA is responsible for surveying and certifying all Medicare

clinical laboratories (hospital based and independent) and interstate commerce laboratories, but not physician office laboratories. The Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), to be effective July 1991, extends such federal oversight to physician office laboratories (perhaps as many as 300,000), and establishes new quality assurance standards for cytology.

Other changes have been directed to the expansion of programs or program benefits:

- The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) provided for Medicare changes removing limits on covered hospital days and hospital coinsurance, and increasing the limits on a number of other covered services, and for a number of Medicaid changes. Although the Medicare expansion was repealed before becoming effective (P.L. 101-234), Medicaid revisions remained that require state Medicaid programs to:

  - Pay Medicaid premium and copayments for individuals eligible for Part A benefits who are poor but not otherwise eligible for Medicaid benefits.

  - Allow spouses of nursing home residents seeking Medicaid coverage to retain more income to protect against spousal impoverishment.

  - Extend benefits to all pregnant women and infants living in families with incomes below the federal poverty line.

- The Family Support Act of 1988 (P.L. 100-485) required state Medicaid programs to extend coverage for 12 months to families who lose cash assistance due to earnings, and to two-parent families where the principal breadwinner is unemployed.

The above are but a few of the many legislative changes and requirements that have affected HCFA in the last few years. For example, HCFA's implementation plan for OBRA 89 identified 83 sections that would affect HCFA programs. There were 170 provisions that required HCFA to develop new or revised regulations and related program instructions and guidance and to undertake or contract out several studies and/or demonstrations. Many of these changes were effective upon enactment or on dates that allowed little time for HCFA to develop the necessary regulations and program instructions and guidance. OBRA 90 (P.L. 101-508) contained a similarly high number of changes and requirements.

With the legislative evolution that has taken place over the years, including many measures to help contain the escalating cost of health care and to control the federal budget deficit, the programs administered by HCFA have become increasingly complex and are in a constant state of change.[1] This circumstance has made the challenge of relating HCFA's workload to needed staff resources increasingly difficult.

The dramatic increase in the level of detail and complexity of the law has correspondingly multiplied the number of areas of expertise and specialized knowledge that must reside in the HCFA staff. To effectively carry out its responsibilities both in developing regulations and program guidance to implement the law and in directing and monitoring program operations, HCFA's staff must have an increasingly comprehensive knowledge and understanding of the many aspects of medical care and treatment and changes in related technology, and of the data and methodologies that must be employed to develop and administer the increasingly complex approaches to payment for such care and treatment.

Growing Call for Restructuring the Health Care System

Rapidly growing health care costs and inadequate coverage of the needs of many Americans have prompted a number of proposals for change in the way health care delivery is organized, the way it is financed, and the way payments for such care are administered. These range from fairly modest proposals for incremental change, to far-reaching proposals for national health insurance to protect virtually all citizens under one program.

While it is impossible to predict which, if any, of the various proposals will find favor, it seems clear that HCFA, currently charged with the major federal responsibility for administering federal and federally assisted health care financing programs, will have a continuing and major role in seeing that such programs are carried out effectively and

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[1] For program descriptions and data, including the identification and a good discussion of the important legislative changes for the Medicare and Medicaid and related health quality programs, the panel refers the reader to Committee Print, House Committee on Ways and Means, 1991 Green Book, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, 1991 Edition, 102nd Congress, 1st Session, GPO 1991, pp. 129-451 and pp. 1404-1437 and to Committee Print, House Committee on Energy and Commerce, Medicaid Source Book: Background Data and Analysis, 1988 Edition, 100th Congress, 2nd Session, GPO 1988, particularly pp. 203-231.

efficiently and that the care provided meets acceptable standards of quality. How well the programs are carried out will depend in large measure on the quality and performance of HCFA staff. With such a critical and challenging mission, it is imperative that HCFA have the institutional capacity to do the job.

CHAPTER THREE

MEETING A GROWING CHALLENGE

The HCFA of today is the product of evolution in organization and in role. It has responded to challenges inherent in its creation and to challenges brought to it through internal and external initiatives during its 14-year history. In this chapter, the panel discusses that evolution and briefly assesses how well HCFA is meeting the challenge of its current responsibilities.

DEVELOPMENT OF HCFA

In its inception, HCFA needed to bring together programs and parts of organizations that differed in their traditions and philosophies and, indeed, in their geographic locations.

- Medicare, a program structured on an insurance model, had been managed by SSA, an agency marked by relatively high continuity and stability in organization and in political and career leadership. Central office operations were located in Baltimore, Maryland; field activities were carried out through regional and district offices (as mentioned in Chapter One, beneficiary intake and some communications functions are still carried out by SSA under arrangements with HCFA).

- Medicaid, a program structured on a needs-based welfare model, had been managed by SRS, an agency that had enjoyed relatively less continuity and stability in organization and in political and career leadership. Central office operations were located in downtown Washington, DC; field activities were carried out through regional offices.

- Health quality assurance functions had been managed by the Office of Long Term Care and the Health Services Administration within the PHS, an organization with a long history and strong traditions, but which had undergone considerable change organizationally and programmatically as new federal health initiatives were brought into being. Central office operations were located in downtown Washington, DC, and Rockville, Maryland; long term care standards enforcement activities were carried out through regional offices.

Restructuring and Relocation

Bringing these different parts together entailed relocation of central and regional office operations and staff and the structuring of a new organization. Over time, HCFA consolidated most central office operations in Baltimore, albeit in several locations, within and near the SSA complex in the Woodlawn area. Initially, HCFA's organizational structure brought together many support functions. However, for the most part, both the central and field offices retained an organizational alignment based on programs. Within about two years, the basic central office organizational structure was reoriented along functional lines. This reorganization brought together, at the bureau level, similar functions from the different programs -- principally program operations, program quality control, program policy development, health standards and quality assurance, and research. In 1981, regional offices were restructured along functional lines, with divisions for program operations, financial operations, and health standards and quality.

The central office has largely retained its functional orientation, but with some departures. The HMO program, which was brought into HCFA in 1986, was placed in a new office, the Office of Prepaid Health Care (OPHC), reporting to the administrator. Also, in the spring of 1990, the operations and program policy development functions for the Medicaid program were brought together into a new Medicaid Bureau (MB) that reports to the administrator.

Regional offices have returned to a program orientation. The transition, completed in fiscal year 1990, took place at different times in different offices over about a two-year period. Each office now has three divisions: Medicare, Medicaid, and Health Standards and Quality.

Adding A Level of Management

Prior to 1981, HCFA's principal headquarters bureaus and offices -- almost all headed by career executives -- reported directly to the HCFA administrator, who was

assisted by a deputy administrator. To reduce the span of control, in 1981, Administrator Davis created four functionally-oriented associate administrator positions. Each had line responsibility for two or more bureaus and offices. Although some name changes were later made, these four positions remain in the present organization as associate administrators for management (AAM), operations (AAO), program development (AAPD), and communications (AAC).

The assigned responsibilities of the associate administrators have remained basically unchanged, except for the following:

- The former Bureau of Quality Control, which reported to the AAO, was abolished at the time the MB was created in early 1990.
- The reporting line of the Office of Legislation and Policy (OLP) was changed in 1986 from the AAPD to the administrator directly.
- In the spring of 1991, OPHC, which had been created in 1986 and reported to the administrator, was abolished and its program operating functions were reassigned to a new Office of Prepaid Health Care Operations and Oversight (OPHCOO) under the AAO. Its planning, policy and promotion functions were reassigned to a new Office of Coordinated Care Policy and Planning (OCCPP) that reports to the administrator.

Information from HCFA indicates that for several years after the positions were established all incumbent associate administrators held noncareer Senior Executive Service (SES) appointments; i.e., they were political appointees. This continues to be the case for the associate administrators for program development and for communications. Since 1985, the AAO and since 1988, the AAM positions have been held by career executives. Aside from the administrator, the deputy administrator, and the associate administrators for program development and for communications, four additional line management positions are held by noncareer SES appointees: the directors of OLP, MB, and OCCPP, and the deputy associate administrator for management.

The Current Organization

The charts on pages 22 and 23 show the current structure of the HCFA organization

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED STRUCTURE As of March 13, 1991

- ADMINISTRATOR / DEPUTY ADMINISTRATOR
  - MEDICAID BUREAU
  - PROVIDER REIMBURSEMENT REVIEW BOARD
  - OFFICE OF COORDINATED CARE POLICY & PLANNING
  - OFFICE OF LEGISLATION AND POLICY
  - OFFICE OF EXECUTIVE OPERATIONS
  - OFFICE OF THE ATTORNEY ADVISOR
  - ASSOCIATE ADMINISTRATOR - MANAGEMENT
    - OFFICE OF BUDGET AND ADMINISTRATION
    - OFFICE OF THE ACTUARY
    - BUREAU OF DATA MGMT. & STRATEGY
    - EQUAL OPPORTUNITY OFFICE
  - ASSOCIATE ADMINISTRATOR - OPERATIONS
    - BUREAU OF PROGRAM OPERATIONS
    - HEALTH STANDARDS & QUALITY BUREAU
    - REGIONAL OFFICES
      - I – BOSTON
      - II – NEW YORK
      - III – PHILADELPHIA
      - IV – ATLANTA
      - V – CHICAGO
      - VI – DALLAS
      - VII – KANSAS CITY
      - VIII – DENVER
      - IX – SAN FRANCISCO
      - X – SEATTLE
    - OFFICE OF PREPAID HEALTH CARE OPERATIONS & OVERSIGHT
  - ASSOCIATE ADMINISTRATOR - PROGRAM DEVELOPMENT
    - BUREAU OF POLICY DEVELOPMENT
    - OFFICE OF RESEARCH AND DEMONSTRATIONS
  - ASSOCIATE ADMINISTRATOR - COMMUNICATIONS
    - OFFICE OF PUBLIC AFFAIRS
    - OFFICE OF PUBLIC LIAISON

TYPICAL RE[illegible]AL STRUCTURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

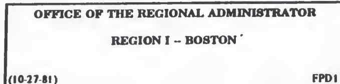
HEALTH CARE FINANCING ADMINISTRATION

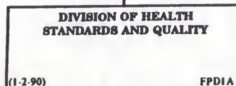
OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR OPERATIONS
OFFICE OF THE REGIONAL ADMINISTRATOR

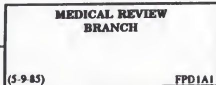
APP[illegible]VED STRUCTURE

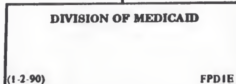
As of January 2, 1990

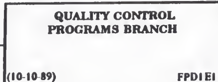
REGION I -- BOSTON

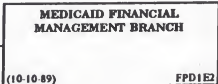


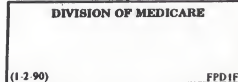


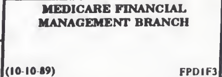












in the central and regional offices, respectively. Most of the central office organizational units and employees are located in 10 buildings in Baltimore. HCFA has been planning for a single consolidated site for some time.

OLP, OCCPP, and parts of the Office of Executive Operations, OPHCOO, and the Offices of Public Affairs and Public Liaison under the AAC are located in downtown Washington, D.C. Offices for the administrator, the deputy administrator, and the AAM are maintained in both Baltimore and Washington.

The 10 regional offices are located in the 10 standard federal regional office cities. They are part of and receive certain administrative support from the respective regional offices of HHS; e.g., support in personnel operations is provided by the HHS regional personnel officer.

Staff Resource Levels

When HCFA was created in 1977, its authorized staff (expressed in "full time equivalents" or FTEs) was about 4,000. Most staff transferred from the agencies that previously had responsibility for the programs HCFA was to administer.

By fiscal year 1980, HCFA's authorized staff level had increased to about 5,000. Over the next few years, during which there was considerable emphasis on reducing the size of the federal government, authorized staff levels were reduced to about 4,100 by fiscal year 1983 and further to 3,856 by fiscal year 1987. During this period, three changes took place in HCFA's basic functions that had direct staff level effects.

1. In fiscal year 1982, HCFA created the Bureau of Data Management and Strategy (BDMS) to consolidate management of program-related automatic data processing and statistical reporting functions that were being carried out in different parts of HCFA, develop a data center, and gradually assume Medicare program data processing functions that continued to be performed by SSA (assumption of these functions was completed in fiscal year 1990). BDMS had an FTE ceiling of 207 for its first full year of operation (fiscal year 1983) which was increased to 345 by fiscal year 1987 and to 372 by

fiscal year 1990.

2. By the end of 1984, HCFA had discontinued a direct reimbursement claims processing function for Medicare Part A that had employed about 300 employees; the claims were subsequently handled by fiscal intermediaries and the displaced HCFA employees were assigned to other duties.

3. In fiscal year 1986, the HMO program functions of PHS were transferred to HCFA; the office created to carry out these functions, together with prepaid health functions already in HCFA, had an FTE ceiling of 108 for its first full year of operation (fiscal year 1987) which increased to 125 by fiscal year 1990.

From the fiscal year 1987 level of 3,856, HCFA's FTE ceiling has risen about seven percent to 4,127 authorized for fiscal year 1991 and proposed in the president's budget for fiscal year 1992. FTE ceilings included in HCFA's initial budget submissions for recent years were reduced somewhat but not drastically during the budget review process at both the departmental and the Office of Management and Budget (OMB) levels; the combined cuts were 138 for fiscal year 1989, 275 for fiscal year 1990, 140 for fiscal year 1991, and 83 for fiscal year 1992. In recent years, staff levels included in the president's budget have not been adjusted significantly by Congress.

HCFA has had, therefore, a relatively fixed level of personnel resources for the past several years with which to carry out its responsibilities, including the implementation of numerous important changes in its growing programs.

It should be noted that although most HCFA staff are HCFA employees, some (recently 85 to 90, 60 to 65 in HCFA's regional offices and the remainder in the central office) are members of the PHS Commissioned Corps who are assigned to work in HCFA. For the purposes of this study, these people were considered along with HCFA employees except where otherwise noted.

Evolutionary Change in HCFA Role

When HCFA was created, the Medicare and Medicaid programs had been in existence

for about 11 years. During this period and for the next few years, they changed relatively little. Their purpose basically was to pay the reasonable costs of institutional care and the reasonable charges for physician services provided to Medicare beneficiaries, to pay the federal share of the Medicaid program costs incurred by the states under approved state plans, and to assure that the care provided under the programs met certain standards of quality.

HCFA's Principal Role Is Operational

HCFA's basic charge has been to implement and manage the major programs that are intended to provide financial access to quality health care for the defined beneficiary populations. Consistent with this charge, most of its resources are applied to functions and activities that are operational in character, such as:

- Translating legislative policy and requirements into regulations and operational instructions and guidance.
- Providing additional policy guidance and interpretation as needed.
- Monitoring program operations of its contractors and the states.
- Collecting and making available program data for research and study purposes.

HCFA carries out research and demonstration activities both through its own staff and through contract and cooperative agreement. An increasing share of this effort is carried out in direct response to legislative requirements and in direct support of regulations development activity. In fiscal year 1990, research, demonstration and evaluation projects accounted for $50 million of HCFA's $1.8 billion for program management activities. Since fiscal year 1984, between four and five percent of HCFA's personnel resources have been assigned to its Office of Research and Demonstrations (ORD).

Impact of Legislation

As outlined in Chapter Two, during the 1980s the pace of legislative and program change picked up dramatically, with much of the change directed toward ways to contain the rapidly increasing costs of health care. A number of those project staff interviewed, both within and outside HCFA, said the principal focus of program administration has moved away from the cost effectiveness of needed health care delivery to program beneficiaries toward ways to either contain or shift the incidence of the costs of such care.

With the implementation of PPS for inpatient hospital care, the potential expansion of PPS to other types of care, and the impending introduction of fee schedules to govern the payment for physicians' services under the Medicare program, HCFA has moved a long way from being largely a paymaster to becoming a price administrator for covered health care. With the upgrading of standards for nursing facilities and clinical laboratories and the expansion of the latter to physician office laboratories, it has moved much more heavily into regulating quality of health care. And with the federally mandated expansion of coverage under the state medicaid programs, it plays a larger role in meeting the health care needs of low income people.

The heavy volume of legislation has had an impact on the difficulty and intensity of the challenge for HCFA's staff to effectively translate legislation -- which is increasingly detailed and complex -- into regulations, operational instructions and guidance, and to monitor program operations against the changed directions and requirements. As mentioned earlier, legislation has required HCFA staff to become more knowledgeable of the many aspects of medical care and treatment, of changes in related technology, and of the methodologies and data that must be employed to develop and administer the complex and diverse approaches to payment for such care and treatment. To accommodate this need, the degree of specialization within HCFA's staff has had to increase significantly.

Limited Role in Basic Policy Formulation

In large part, the program changes have not been of HCFA's making; it has mainly responded to the initiatives of others. During the 1980s, the political agendas of both the administration and Congress have been tilted heavily toward containing costs and reducing the federal budget deficit. The Medicare program in particular, with large dollar outlays, became a popular target for cost containment and reduction for both the administration and the committees of Congress. For example, according to the House Ways and Means Committee Green Book cited earlier (see page 17), the combined effect of some 37 sections of OBRA 90 was to reduce Medicare outlay growth by about $43 billion for the five-year period ending in fiscal year 1995. At times, HCFA has been caught in the middle as Congress and the administration have vied for credit over certain cost saving measures. Some of this contest resulted in moving implementation dates from one fiscal year into another without regard for the operational feasibility of advancing the date.

During the 1980s, the administration was not very active in initiating basic program changes or expansions. The one major exception was catastrophic health insurance, which, although enacted, was short lived; this proposal was developed at administration levels above HCFA. Most major program changes, including extensions of quality assurance programs, expansions of the Medicaid program, and the reform of payment systems for hospital and physician care under the Medicare program were principally the product of congressional initiatives.

Congress has placed many requirements on HCFA for the conduct of research studies and demonstrations to assist it in its formulation of policy and has also turned increasingly to Congressional support agencies -- Congressional Budget Office, Congressional Research Service, General Accounting Office, and the Office of Technology Assessment (OTA) -- and others for studies and analyses in support of its policy making functions.

In the areas of payment policy under Medicare, Congress has created two independent agencies to conduct policy analysis and render advice. The Social Security

Amendments of 1983 (P.L. 98-21), which authorized the implementation of the PPS, required the director of OTA to appoint a commission of independent experts, known as the Prospective Payment Assessment Commission (ProPAC). ProPAC, which has 17 members, consults with and makes recommendations to the secretary of HHS on the need for adjustments to the medical treatment classifications (diagnosis-related groups or DRGs), that serve as the bases for payment, the methodology for classifying specific hospital discharges within the DRGs, and the weighting factors for the DRGs. It reports to Congress its evaluation of any adjustments the secretary makes. It also reports annually to Congress on trends in health care delivery and financing, including the impact of the PPS on providers and beneficiaries.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272) created a similar commission, the Physician Payment Review Commission (PPRC), to make recommendations regarding Medicare physician payments. This commission will have continuing responsibilities as the fee schedule for physician payments authorized by OBRA 89 is developed and implemented.

According to many people project staff interviewed, Congress's increasing reliance on its own staff and on organizations outside the executive branch for policy analysis and advice is grounded in a less than fully trusting relationship between the two branches, which have been controlled by different political parties with different views and priorities regarding human services programs.

HOW WELL IS HCFA DOING?

The following brief panel assessment of how well HCFA is meeting the challenges it faces is based on interviews both outside and within HCFA and on review of selected documentation.

The View From Outside

In general, interviewees outside HCFA have a relatively high regard for the performance of HCFA and for the competence and responsiveness of the HCFA staff with whom they have contact. They believe HCFA is generally responsive to program needs including most required policy direction and operational guidance. Many went of out their way to observe that they thought HCFA and its programs have benefitted greatly from the efforts of many very competent and dedicated senior level staff who have chosen to remain with HCFA and do their best to effectively administer the programs for the benefit of the beneficiary populations, despite great difficulties.

In discussing the more significant areas of concern, interviewees generally expressed a high degree of empathy for HCFA's challenge to manage numerous program changes in the face of budget constraints and uncertainties and tight timeframes; most thought that it did quite well considering the circumstances.

Often Too Slow in Developing and Promulgating Regulations and Other Guidance

The most pervasive problem cited was that HCFA was often too slow in developing and promulgating regulations and operational guidance required to implement legislative and other policy changes. In some cases, because of unrealistically tight statutory deadlines for implementation, HCFA issues policy guidance to the parties needing to take action, with the intent that this guidance will be incorporated into regulations later. This practice can cause difficulties if significant policy interpretation differences arise between the early guidance and the final regulation.

The most severe dissatisfaction centered on major regulations in the Medicaid program and quality assurance areas involving complex and difficult issues. Dissatisfaction in these areas was well documented in a May 1990 report prepared for the Administrative Conference of the United States (ACUS), which reviewed experience with rule making and

policy making for the Medicaid program in the 1980s[2], and in related recommendations to HCFA and Congress by the ACUS in December 1990.[3]

In its recommendation, the ACUS stated that:

> Of primary concern is that Congress, in annual budget legislation, . . . has either made the expansion of benefits effective regardless of whether or not HCFA promulgates implementing regulations or other guidance by a certain date or has made the expansion effective immediately. . . . These provisions place a great burden on HCFA to issue rules, policies, or other guidance at an accelerated pace and, due to this time pressure, as well as HCFA's reluctance or inability to promulgate implementing regulations and policies, states are often forced to implement program changes without federal guidance.
>
> . . . These delays have imposed hardships on states. . . . Where HCFA has failed to issue rules or policy, does not act expeditiously on a state's plan amendment to implement a congressionally-mandated change, or promulgates new rules or policies strictly interpreting a legislative program change, states are at risk of having to return the federal payment if HCFA determines that a state's proposed plan amendment inaccurately implements the statutory change.

Inadequate Surveyor Training and Oversight

Representatives of state survey agencies, as well as officials of some state health care associations representing nursing facilities, expressed concern that HCFA does not provide adequate training for the surveyor staff of state survey agencies and of HCFA regional offices. The content of basic training for new surveyors was considered to be satisfactory, but the number of training opportunities available was not believed sufficient to meet the needs of the increased number of surveyors required to implement expanded survey requirements. HCFA's approach to training existing surveyors for the new survey

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[2] Rule and Policy Making for the Medicaid Program: A Challenge of Federalism, prepared for the Administrative Conference of the United States, Eleanor D. Kinney, J.D., M.P.H., May 7, 1990.

[3] ACUS Recommendation 90-8, Rulemaking and Policymaking in the Medicaid Program, 1 C.F.R. §305-90-8.

requirements under OBRA 87 is to make the survey manual available for self instruction and to train a few surveyors in each state and regional office with the expectation that they will train the remainder of the surveyor staff. Commentators generally did not believe that this approach results in adequately trained staff or provides reasonable assurance that requirements are applied consistently throughout the country.

In addition, some state health association representatives expressed concern that HCFA's regional offices and surveyors are inconsistent in their application of requirements and that regional offices tend to be too accepting of the regulatory philosophies of the states within their respective regions, accepting both relatively lenient and relatively harsh application of what are intended to be uniform federal requirements. They believed that HCFA should provide more central oversight of regional offices to better assure consistent application of requirements.

Review of Provider Payment Provisions of State Medicaid Plans

Hospital and health care association representatives expressed concern that HCFA regional office reviews of state Medicaid plan provisions covering payments to providers for beneficiary care were not in enough depth to judge compliance with requirements of federal law that such payments be reasonable and adequate to meet the costs of efficiently and economically operating facilities. Assertions by providers of noncompliance with these requirements, which are admittedly difficult to apply, have led to a considerable amount of litigation between providers and states.

Research and Policy Analysis Seen As Reactive and Short Term

Many interviewees expressed the view that HCFA's research and policy analysis capacities are absorbed primarily by reacting to demands from Congress and the administration and by short-term issues in direct support of its efforts to develop required program regulations and policy guidance.

Adequacy of Medicare Contractor Funding

Medicare contractor representatives and others expressed concern that funding levels were not adequate to make possible the appropriate level of "payment safeguards" activities intended to assure that Medicare pays only for appropriate care for which the program is financially responsible. They stated that although everyone seems to agree that additional spending for these activities would be offset many times over by reduced program costs, as has been repeatedly reported by the General Accounting Office, sufficient funds for these activities have not been available. They pointed out a dichotomy in that under current budgetary rules, potential savings in "entitlement" funds, which include Medicare benefits, are not allowed to be used to directly justify expenditures in "discretionary" funds, which include the costs of administering the Medicare program incurred through contract as well as within HCFA. Hospital association representatives also cited inadequate funding of contractors as a reason that payments to hospitals are sometimes not timely, causing cash flow problems for hospitals.

Neither contractor nor hospital representatives were inclined to hold HCFA directly responsible for contractor funding shortfalls; they attributed the situation to the general fiscal constraints applied with respect to discretionary funds by the administration through OMB in the budget formulation and execution process.

The View From Inside

The internal view is largely consistent with the external view. Most interviewees believe that most essential things are getting done quite well in a reasonably timely manner. But they also believe that the organizational capacity is quite stretched so that some things that should be done are being neglected, as illustrated in the following four examples:

1. The need to invest more resources in the development of regulations and guidance: high priority regulations get issued, although complex and controversial regulations sometimes suffer significant delays to resolve difficult issues and properly consider public comments; lower priority efforts can languish for long periods (e.g., the Bureau of Policy Development (BPD)

reported in the spring of 1990 that no work was being done on the development of 91 needed regulations). This matter is discussed more fully below.

2. The need to invest more resources to look at what HCFA does and how it does it to find ways to improve operations.

3. The need to invest more resources in policy analysis that is more proactive and has a longer-term outlook.

4. The need for managers and supervisors to have more time to devote to supervising and coaching subordinates, thereby improving the level and quality of on-the-job training and development. At present, the urgency of much of the work requires that they spend much time doing or redoing technical work that could and should be done by others and that would often provide a good learning experience for subordinates.

Regulations Development

The problem of timely regulations development has been recognized. In the spring of 1990, the administrator asked an internal task force to review the development process and recommend improvements. Based on the task force recommendations, in May 1990, the administrator directed changes in the process and asked for a review of the experience after the changes had been in effect for about six months. The changes revised timeframes for the several stages of the development and review process (including review at the HHS and OMB levels), and improved procedures for resolving issues in cases where conflict arose. The timeframes were established separately for two general classes of regulations: complex and normal.

After six months of experience under the revised process, the task force recommended adjustments in some of the timeframes, mandatory use of conflict resolution procedures, and replacing the complex vs normal distinction with a priority vs routine distinction. The latter recommendation was based on a finding that regardless of complexity, in practice, high priority regulations should and did move more quickly through the process. The review was not conclusive as to whether the revisions had resulted in speeding up the regulations development process.

In general, each regulation development effort is carried out by a rather informal team made up of representatives from several bureaus and offices (and the HCFA division of the HHS Office of General Counsel), and led by a representative of a designated "lead" bureau. Team members work together informally and most have other duties. The task force did not have available comprehensive data on how long it takes to accomplish different steps of the process for different types of regulations or the amount of staff effort required. Obtaining such time-frame data would be difficult because most of the logs and control records of the process are kept manually and are maintained in different locations in the agency. The amount of staff effort that goes into regulations development is not recorded for the different steps in the process, for individual regulations, or in total.

The papers generated in the task force effort did not deal significantly with the role that staffing levels play in the timeliness of the development process, and the task force did not recommend that more resources be devoted to regulations development. The tone and content of some of the papers, however, clearly suggest that process changes without additional resources can be expected to result in only limited improvement.

Surveyor Training

HCFA recognizes that surveyor training is inadequate and has made plans and budgeted resources to increase staff devoted to this area as well as to develop teleconferencing facilities to help make training more timely and efficient. Teleconferencing facility plans have been put on hold pending decisions on a single site for central office operations.

Other Internal Initiatives

As mentioned earlier, shortly after taking office, Administrator Wilensky established the Medicaid Bureau to provide more visibility and management focus on issues in that program. This move was quite favorably viewed by interviewees both within and outside HCFA as offering encouragement that the program and some of the difficulties facing the

states would get more effective attention. She has also recently placed the operations functions of the former OPHC under the AAO and has further consolidated automated systems activities in BDMS.

The administrator also:

- Established a Beneficiary Education Policy Review Committee and a subordinate Beneficiary Education Work Group to find ways to help reduce confusion and misunderstanding by older Americans about the Medicare and Medicaid programs. Some of the recommendations resulting from these efforts are being implemented within existing levels of resources.

- Established a task force, led by the deputy administrator, to look at the whole area of Medicare contracting and suggest improvements. This work is underway.

- Asked for an organizational realignment of OLP, with a small increase in authorized staffing. One purpose of the realignment was to devote more effort to policy analysis with a longer-term outlook as well as to use and challenge less senior OLP staff more effectively.

HCFA Staff Opinions

Several of the questions included in the employee survey were directed to gaining insights about how HCFA staff feel about the work of the agency, its contribution, the part the respondents and their co-workers play in making that contribution, and the general quality of co-worker efforts and attitudes. The overwhelming majority of responses were positive to neutral; relatively small fractions were negative. For example, percentages of staff who gave positive to neutral responses were:

- 80 percent on the challenge of their work;
- 87 percent on liking their work;
- 87 percent on the worthwhile nature of their work;
- 89 percent on their understanding of how the work of their unit contributes to overall HCFA objectives;
- 90 percent on whether their co-workers do a good job;
- 95 percent on whether their co-workers were cooperative.

The responses of managers and supervisors were slightly more positive than those of non-supervisors.

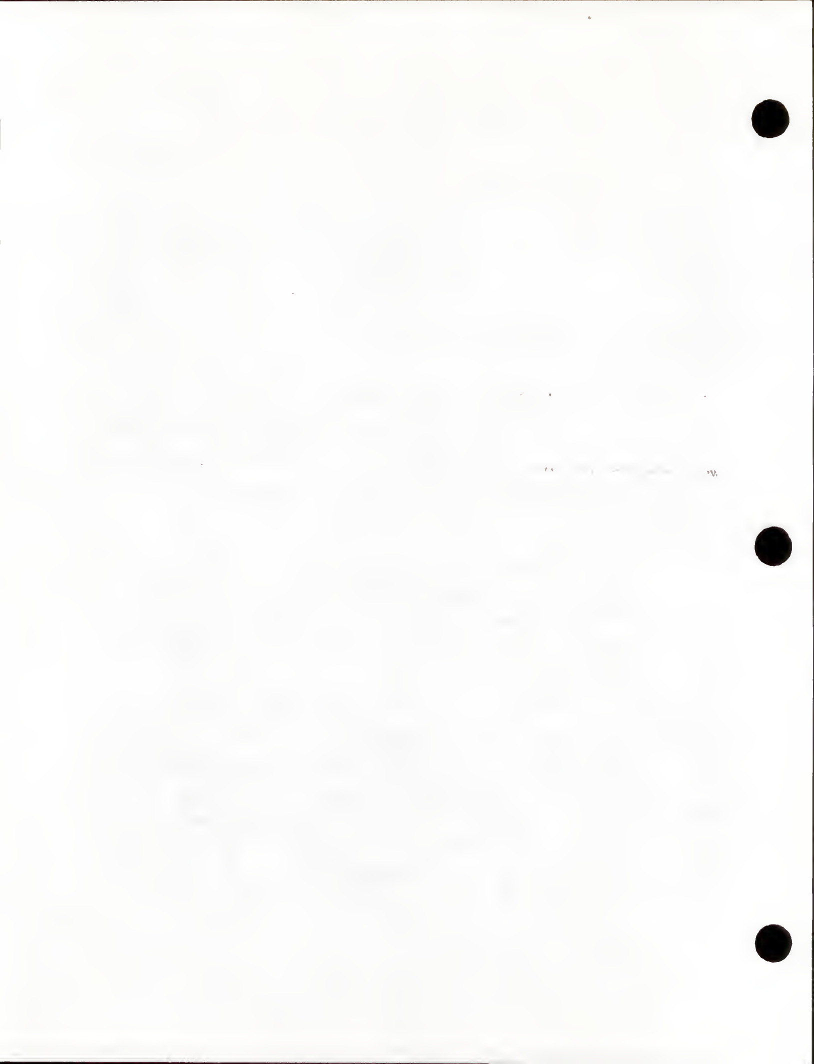
This information is consistent with the views expressed by most senior HCFA managers interviewed that workforce morale was generally high, with negatives stemming primarily from factors affecting the federal workforce in general rather than factors unique to HCFA.

Conclusions

Based on the information at hand, the panel believes that HCFA is meeting its difficult challenges reasonably well. Although there are clearly some significant shortfalls, it is not an agency whose programs are in serious disrepair or are failing to deliver intended benefits to the populations they are intended to serve. Nor is it an agency that suffers from low staff morale; in fact, HCFA staff morale is quite good.

The administrator is directing attention to some important issues to try to improve HCFA's performance, including the issue of timely development of regulations and guidance needed by the organizations and individuals involved in operations of the large programs HCFA administers.

It is clear to the panel, however, that HCFA is being stretched to and perhaps beyond its present capacity by the challenges it must meet, particularly in the area of effectively implementing a heavy and continuing workload of legislative change. The panel has considerable doubt whether sustained improved performance in the important area in which HCFA most frequently gets relatively poor marks -- timely development of regulations and guidance -- can be achieved by prescribing process timetables without thoroughly understanding the resources requirements associated with the process.



CHAPTER FOUR

THE HCFA WORKFORCE: NOW AND IN THE FUTURE

Having assessed HCFA performance, the panel next examines the state of the HCFA workforce. Questions discussed in this chapter include changes in staff levels, the adequacy of staff in terms of both numbers and quality, and age distribution of the staff with particular attention to future implications of the current age distribution.

WORKFORCE DATA LACKING

HCFA lacks a workforce management information system. Interviews with OHR staff revealed there are no regular reports prepared on workforce trends. Regularly prepared reports cover only current staff.

In addition, there is no archival capacity in the human resource data system. For example, no historical data are readily available on fundamental matters such as staff numbers, grades, occupational distribution by organizational unit, accessions and attrition. No data are available on the educational profile of the staff, nor are reports available on staff training.

Consequently, it was necessary for project staff to request HCFA to prepare data reports using departmental history and personnel transaction computer tapes. Reports for all General Schedule (GS) and General Management (GM) staff as of the end of fiscal years 1984-1990 were prepared. These reports were used to analyze grade and occupational change for the agency as a whole and for individual bureaus and offices.

Special reports covering selected occupational series were prepared on the age distribution of staff for the end of fiscal years 1984, 1987 and 1990; on new hires by major agency component for the period 1984-1990; on employees eligible for retirement, currently and at specific future dates; on separations by component for the period 1984-1990; and on the occupational distribution of staff by major agency component. These reports include

grades GS-5 and above in the 12 major professional and administrative occupations in the agency, which numbered 2,782 persons as of 1990.

The 12 occupational series used for these reports are social science analyst (101), economist (110), administrative officer (301), computer specialist (334), program manager (340), management analyst (343), program analyst (345), financial administration (501), accountant (510), auditor (511), health scientist (601), and contracting officer (1102). The 1984 to 1990 period was used because no departmental transaction data tapes are available prior to 1984. Appendix F provides HCFA staff distribution in these 12 occupations for each year from 1984 through 1990.

Unfortunately, there are questions about the accuracy of the data provided. For example, comparisons of reported hires and reported separations cannot be reconciled with total employment in the major occupations for the same periods. In another example, HCFA provided a listing of all new central office hires of professional and administrative staff for 1989-1990. This list contained 169 personnel actions; of these, project staff estimate that 103 resulted in new employees joining HCFA. However, the report HCFA prepared from the transaction tapes on new hires in the 12 major occupations for the same time period indicates there were 221 new central office hires in these occupations alone. The data problems were so serious that project staff were unable to derive reliable data and trends on workforce turnover rates for the agency as a whole or for the individual components.

Finally, since the transaction tapes do not contain information on educational attainment of employees, the employee survey was designed to develop additional information on the workforce. It is with these limitations that the panel presents the following analysis of the HCFA workforce. The data cited are the best estimates that could be made based on the information HCFA provided but should be considered approximations.

The Office of Budget and Administration (OBA) has now initiated efforts to define HCFA's workforce data needs. The findings will be used to develop a system that can produce useful information.

MAJOR STAFF CHANGES

As noted in Chapter Three, total HCFA staff levels have varied considerably during the past ten years. From about 5,000 in 1980, the total authorized staff level is now just over 4,100. Staffing reductions during this period were greater in the regions than in the central office; staff levels in some regions declined 30-40 percent.

There were other significant changes in HCFA staffing during this period. One change was a shift in the occupational mix among the agency's 12 major professional and administrative occupations. During 1984-1990, staff assigned to:

- Program analyst positions increased from 30 to 36 percent.
- Administrative positions decreased from 32 to 28 percent.
- Accounting positions decreased from 9 to 6 percent.
- Computer specialist positions decreased from 11 percent to 8 percent.

During this same 1984-1990 time frame, there was also a shift in the staff in these 12 occupations from the regional offices to the central office. In 1984, about 1,116, or 43 percent, of the 2,600 employees in these occupations were assigned to a regional office. By 1990, there was a decline in the regions to about 1,059, or 38 percent, of the 2,782 staff in these same occupations.

Another change reported in the interviews, but which cannot be directly confirmed by available data, is an increase in the number of clerical and technical staff promoted to professional and administrative positions during the last ten years. There is no information for earlier years on the number of staff in professional and administrative positions who were promoted from clerical and technical positions.

According to the survey data, more than one-third of all respondents who reported they are currently working in professional and administrative occupations indicated they started in technical, clerical or wage grade positions. As shown in the following table, there is a substantial difference in the career patterns of supervisory and managerial staff

compared to non-supervisory professional and administrative staff. Twenty-two percent of the supervisory and management staff reported that they started their career in a clerical, technical or wage grade position. In contrast, 37 percent of the non-supervisory professional and administrative staff reported they started their career in such a position.

TABLE IV-1

Professional/Administration Staff Who Report Starting Career in a Clerical, Technical or Wage Grade Position

	Position Started In			
	Technical	Clerical	Wage Grade	Total
Supervisor/Manager	15.0	7.1	0.4	22.4
Central Office	14.5	8.4	0.6	23.5
Regions	15.9	4.5	0.0	20.5
Non-Supervisor/Manager	13.2	23.1	0.5	36.8
Central Office	14.1	27.6	0.4	42.1
Regions	12.0	16.2	0.6	28.7
TOTAL	13.6	19.8	0.5	33.9

Forty-nine percent of the non-supervisory professional and administrative staff in GS-12 and below reported that their first position in HCFA was in a clerical, technical or wage grade occupation. In contrast, only 22 percent of non-supervisory staff GS-13 and above and, as indicated in the chart above, 22 percent of supervisors and managers reported that their first position was in these occupations. Also, compared to all managers, a higher percentage of managers under age 40 (30 percent) reported that they started in HCFA in a clerical or technical position. Overall, the available information tends to confirm a shift in staffing practices toward increased promotion of clerical and technical personnel to professional and administrative positions.

HCFA's staffing practices during the 1980s were heavily affected by frequent hiring freezes and restrictions. In January 1982, the administrator imposed a hiring freeze. Relaxed somewhat in May of that year, hiring restrictions were continued until May 1983. In May 1984, HHS imposed a freeze on filling positions for which Office of the Secretary employees were available; some hiring restrictions were continued through 1985. In January 1986, the HCFA administrator imposed a freeze on outside hires. This was followed by a departmental hiring freeze in February, which in March was relaxed somewhat to allow HCFA to hire one replacement for every three staff losses. HCFA imposed another freeze on outside hires in November 1987 and the HHS secretary imposed still another in August 1990 that lasted about two months. These hiring restrictions have severely limited the agency's ability to conduct a sustained recruitment program.

DOES HCFA HAVE ENOUGH STAFF?

As discussed in Chapter Two, in a staff organization such as HCFA, most workload is not easily measurable. The panel had to rely primarily on informed judgments to determine the adequacy of workload and staff level relationships. Project staff discussed the question in interviews with senior HCFA managers and with officials in the health care industry, a number of whom had worked in HCFA. In addition, a number of survey questions were designed to secure employee opinions on workload and the adequacy of staff levels.

Not surprisingly, interviewees outside HCFA did not offer strong views on this question. Some individuals with prior HCFA experience indicated that top quality people in many parts of the agency are being asked to do more than is reasonable.

Some outside interviewees commented that staff reductions have taken their toll in that new staff see diminished advancement opportunities and not enough new blood is being brought into the agency at the lower professional grade levels. Most of the outside interviewees did indicate, however, that there was no strong evidence of staff shortages getting in the way of HCFA's outside relationships except for delays in producing some regulations and program guidance material. They generally found HCFA quite responsive.

Associate administrators, directors of bureaus, offices and divisions, and regional and associate regional administrators expressed a consistent view that at present staff levels they are always running to catch up to get essential work done. There is inadequate time, they reported, to supervise and coach subordinates and thereby improve the level and quality of on-the-job training and development. The urgency of the work requires that they spend much time doing or redoing technical work that could and should be done by lower level staff and would provide a good learning experience for them. These managers also indicated that the best staff are consistently overworked while other staff are, for the most part, fully employed with important work.

Almost all of the senior managers discussed the staff reductions of the 1980s. However, hardly anyone argued that HCFA needed to return to the 5,000 person staff level; most talked of a needed increase of 10 percent or less in their units.

Six of the employee survey questions have some value in providing an understanding of how HCFA staff and managers feel about workload and staff levels. Responses from non-supervisory professional and administrative staff and from supervisors and managers tend to be consistent with the interviews with senior HCFA managers. Large percentages of both groups disagreed with questions such as "My unit has too many staff for the work assigned" and "My unit has enough staff to do the job right and on time."

One question, asked only of managers and supervisors, requested a judgment on the adequacy of the number of professional and administrative staff in units they supervised in relation to the work assigned to the unit. Of 542 respondents:

- Only 10 (2 percent) judged the number of staff to be in excess of the need;
- 156 (29 percent) said staff levels are about right;
- 169 (31 percent) said staff levels are inadequate with up to 10 percent more staff needed; and
- 207 (38 percent) said staff levels are very inadequate with more than a 10 percent increase needed.

Another question asked only of supervisors was if the units they supervised had enough clerical and technical staff. About two-thirds of the respondents answered this question negatively.

Understaffing concerns appear to be slightly higher in units having a policy development orientation (OLP, BPD, ORD, and AAPD) compared with units that are more oriented toward operations (MB, the Bureau of Program Operations (BPO), the Health Standards and Quality Bureau (HSQB), and AAO). The table below contrasts the responses of these two groups of organizations on two of the workload questions.

TABLE IV-2

Workload Question Response: Operational and Policy Units

	Policy Units	Operational Units
· My unit has too many staff for the work assigned.		
Disagreement by:		
Supervisors	96%	88%
Non-Supervisors	80%	77%
My unit has enough staff to do the job right and on time.		
Disagreement by:		
Supervisors	72%	62%
Non-Supervisors	45%	47%

The responses to these questions also indicate that supervisory and managerial staff feel greater workload and understaffing pressures than do rank and file professional staff. This pattern is consistent in the responses to all of the workload and staff level survey questions by all HCFA supervisory and non-supervisory professional and administrative staff. Appendix G provides the responses to these questions by the two staff groups.

Finally, project staff briefly inquired into the appropriateness of HCFA's use of contracts in lieu of performing work with its own staff to determine if this gave any indications of severe understaffing problems. Project staff obtained a listing of all administrative contracts (contracts for other than program operations) for the past five fiscal years and asked knowledgeable HCFA staff to identify those contracts for which there would have been an option, had staff with proper qualifications been available, to perform the work with federal staff. Although an argument might be made that some contracts should have been performed by HCFA staff, the panel believes that contract efforts seem to be generally of the type and in circumstances that justify contract assistance rather than staffing up to do the work within the agency.

Overall the panel finds that the weight of the evidence indicates some degree of understaffing in HCFA, even recognizing respondent bias in the interview and survey data. The level of understaffing is probably less than 10 percent, and is certainly not at the 20 percent level that would be needed to restore the staff cuts the agency underwent in the 1980s. The data also indicate that understaffing is fairly evenly distributed among all major units; no strong evidence was found to suggest that any major reallocation of staff resources is in order.

TURNOVER NOT A MAJOR PROBLEM

Staff turnover does not appear to be a major problem in HCFA. As best as can be estimated, turnover of professional and administrative staff has been in the five-seven percent range. The project staff have examined non-retirement separation data for senior staff for a three-year period, fiscal years 1988-1990. These data show that there were no more than 24 career losses at the grade 14 and 15 level; 18 were at grade 14 and six at grade 15. Also, out of about 30 career SES employees, there were five losses for the three-year period: four went to other agencies and one went to the private sector.

There are individual bureaus where turnover is higher. For example, data provided by OLP for the three-year period 1987-1989 show attrition at levels more than three times

higher than those for HCFA as a whole.

BEYOND NUMBERS: IS QUALITY PRESENT?

Staff quality, like the adequacy of staff levels, is difficult to assess. Here again, interview and survey data are the principal sources of information from which the panel made its judgment.

A majority of the interviewees from outside HCFA offered fairly strong views that the HCFA staff with whom they deal are mostly first rate. Most were quick to add, however, that their perspectives are limited in that they primarily deal with senior people in their respective areas of responsibility and/or expertise and they are probably working with the "cream of the crop."

Outside interviewees who deal with staff at lower organizational levels in HCFA are less positive. A number of negative comments were made regarding the qualifications of non-supervisory staff. Another area of concern involves what is seen as a lack of day-to-day business experience in the health industry on the part of HCFA staff. The view was also expressed that HCFA is beginning to get short of people in the middie of the organization with real expertise and dedication.

Concern over the depth of talent below the supervisory levels ready to move into higher level positions was also heard in the interviews with senior HCFA managers. They consider a good proportion -- in the 15-20 percent range -- of the non-supervisory professional staff very good technically, but believe only a limited number of the very good technical staff have clear potential to move into supervisory and management positions. Senior managers consider the balance of the staff -- although competent at what they do -- to have limited or questionable potential to assume leadership positions. A number of managers also indicated in the interviews that in making recent selections for senior positions, it has become more difficult to find really high quality candidates on the list of those best qualified for promotion.

Senior managers indicated in the interviews that a relatively small proportion of the professional staff -- fewer than five percent -- are poor performers. Survey responses on questions related to staff quality as demonstrated in the workplace were generally consistent with interview data. Most professional staff think their co-workers are generally well-qualified, do a good job, are industrious and conscientious, and have good work habits and attitudes. Most supervisors think their staff's performance is generally good or better. Only eight percent of the supervisors report that there are too many poor performers or that performance is not up to par.

Data on the performance ratings assigned in 1989 was also reviewed. However, this review did not provide any useful information on performance levels. As is generally the case in large organizations, few staff were formally rated as performing below the fully successful level. In that year, only 20 of 3,291 non-supervisory staff were rated below the fully successful level and ten of these individuals were at grade seven and below which means they were most likely clerical or technical staff.

Whatever the number of poor performers, it is clear that dealing with poor performance is a problem. Almost half of all supervisors and managers who responded to the survey reported that dealing with poor performers or performance appraisal is their greatest personnel management problem.

There is another survey finding that is inconsistent with the more optimistic reports on staff quality. While most supervisors (75 percent) believe that their staff's knowledge and skills are appropriate to the work assigned to their unit, a significant group (25 percent) believe their staff need significant retraining and skills upgrading or that new staff with other knowledge and skills are needed.

Views expressed in the focus group discussions are also somewhat contradictory to the generally positive assessment of staff provided by the interview and survey data. In each session, participants expressed the view that toleration of poor performers is having a negative impact on staff morale. This view was generally concurred with by the other

group members. Finally, almost 100 individuals added a written comment on the employee survey to the effect that toleration of poor performers by the agency is creating more work for the good performers.

Later interviews with senior managers included discussion of the difficulties of dealing with poor performers. The views expressed were consistent with those often heard in the federal service. They reported that it is too complicated and time consuming to take an adverse action; workload pressures do not allow supervisors to devote the time needed to take such action. Therefore, they take such actions only as a last resort when the employee creates problems in the workplace that are disruptive and time-consuming in themselves. These HCFA managers are not alone in their response to poor performers. Dealing with performance appraisal and poor performers is a long-standing problem in the federal government[4].

The general view expressed in the HCFA senior manager interviews is that supervisors are top quality in a technical sense but often are not as strong managerially. The same view is evident in the survey response data. Professional staff members express less satisfaction with their supervisors' supervisory and managerial abilities than with their technical abilities. More than 84 percent of the professional staff indicate satisfaction with their supervisors' technical ability. In contrast, 72 percent express satisfaction with their supervisors' supervisory and managerial abilities.

Another staff quality indicator is the educational level of the employees. More than 70 percent of the professional and administrative staff have at least a bachelor's degree; more than one-quarter of the professional and administrative staff have advanced degrees.

Staff at grades 13 and above are more highly educated. Eighty-six percent of the staff at GS-13 and above, and 88 percent at GM-13 and above have a bachelor's degree or above. One-third of the GS-13 and above staff, and 38 percent of the GM-13 and above

[4] For a discussion of the difficulties in dealing with poor performance and performance appraisals in the federal government, see GAO report "Performance Management: How Well is the Government Dealing with Poor Performers?" GAO/GGD-91-7, October 2 1990.

staff have received advanced degrees. In contrast, 55 percent of the current professional and administrative staff at GS-12 and below hold a bachelors's degree or above while 18 percent hold advanced degrees.

The survey also addressed the quality of new hires. Supervisors and managers were asked to describe, for the period they had been a supervisor, whether the quality of new staff hired had improved, stayed the same, or deteriorated. Professional staff hires were considered to have improved by 33 percent of the supervisors, remained the same by 39 percent and deteriorated by 29 percent. The quality of new clerical and technical staff hired was considered to have improved by only 19 percent of the supervisors, to have remained the same by 28 percent, and to have deteriorated by more than half (53 percent).

The picture of staff quality presented by these data is somewhat contradictory. The quality of senior staff appears to be high. Staff below the managerial and supervisory levels have varied levels of capability and appear to be reasonably well matched with the jobs they are now doing. However, the panel believes there are serious questions as to whether there is enough depth of high-quality personnel to have an adequate pool of talent from which to replace current managers.

THE GRAYING OF HCFA

To secure an added perspective on the ability of HCFA to replace its current supervisors and managers, the panel examined the age distribution of current staff and retirement eligibility projections.

According to survey data, the median age of HCFA staff is in the 40-49 year range. Seventy-one percent of the staff are 40 years or older; 25 percent are 50 years or older. The following table shows the percent of supervisors and non-supervisory professional and administrative staff 50 years and older. As the table shows, regional supervisors and managers are older than their central office counterparts. Regional professional and

administrative staff are also older than their central office counterparts, but by a less significant degree.

TABLE IV-3

Percent of HCFA Professional and Administrative Staff 50 Years or Older

	Supervisors/Managers	Non-Supervisory Staff
Central Office	30%	23%
Regional Offices	41%	26%
TOTAL	33%	24%

There is also a significant difference in the age of supervisors and managers when individual office units and regions are compared. Major central office units with the highest percentage of supervisors and mangers 50 and older are:

- BPD with 42 percent
- MB with 35 percent
- HSQB with 32 percent
- BPO with 30 percent

Regions with the highest percentages are:

- Boston with 62 percent
- New York with 58 percent
- Dallas with 54 percent
- Denver with 47 percent
- San Francisco with 46 percent

The data on the age of the staff in HCFA's 12 major professional occupations show that over the past six years there has been a significant aging of the supervisory and non-supervisory staff. This has occurred despite a growth of the workforce in these occupations during this same period from 2,600 to 2,782. Figure IV-1 shows the change in the age distribution of the employees in these occupations over this time period. Staff in the age

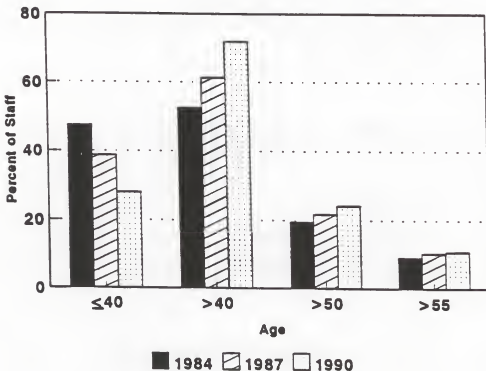
40 and below category declined from 48 percent in these occupations in 1984 to about 28 percent in 1990. Staff over 50 increased from less than 20 percent in 1984 to almost 25 percent in 1990.

In 1990, the median age was in the 40-50 year range for all 12 occupations. During the period 1984-1990, the median age increased by one five-year increment in six of these occupations. These occupations accounted for 1,354 of the 2,782 staff. The median age increased in five of the remaining six occupations, but not by a five-year increment. There was a decline in median age in one occupation which has a population of only 52 employees.

FIGURE IV-1

Change in Age Distribution 1984-1990

12 Major Professional Occupations



By 1990, in these 12 occupations, there is almost no difference in the median age between supervisory and non-supervisory staff at grade 13 and above, and there is relatively little difference in median age between staff at GS 12 and below and all staff. This situation is graphically illustrated in Figure IV-2 which compares the age distribution of these three groups of professional staff as of 1984. A comparison with Figure IV-3, which shows the age distribution for the same three groups as of 1990, illustrates the changes that have occurred. It is significant that in 1984 the feeder groups for supervisory positions were significantly younger than the supervisory staff; by 1990 this difference has largely evaporated.

The median age group for staff at GS-13 and above was the same as for those at GM-13 and above in four of the occupations, including the two largest -- administrative officer and program analyst. The GS median age was actually higher than for the GM group in three occupations and lower for three. The program manager occupation includes no GS staff.

As of 1990, the median age of staff in GS-12 and below grades and that of all staff in these occupations was in the same age interval for seven of the 12 occupations. These occupations include 87 percent of the staff in the 12 occupations.

Given the current age distribution of the HCFA staff, it is not surprising that a substantial proportion will be eligible to retire by the end of 1997. Twenty-eight percent of the survey respondents said they would be eligible to retire by 1997. This includes 27 percent of the non-supervisory professional and administrative staff and 40 percent of the supervisor and management staff. In the 12 occupational groups, 25 percent will be eligible to retire by the end of 1997. Current retirement eligibility is not significantly different between GS and GM-13 and above staff and GS-12 and below staff in a number of these occupations.

FIGURE IV-2

Age Distribution

Group Comparisons - 1984

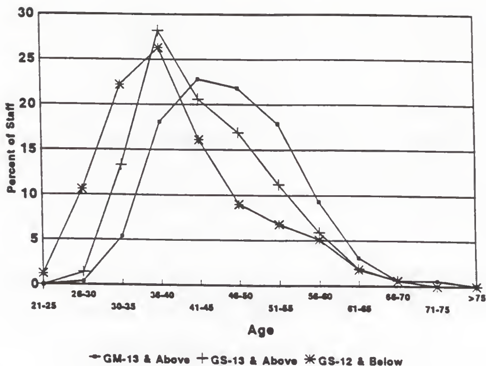
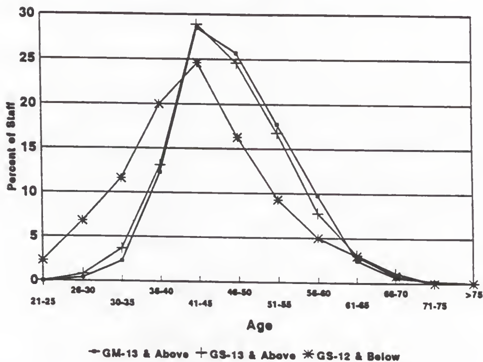


FIGURE IV-3

Age Distribution

Group Comparisons - 1990



There are considerable differences in the retirement eligibility of staff in the major occupations among the key organizations. The following table shows that retirement eligibility is twice as great in these occupations in BPO and BPD compared to HSQB and ORD. This disparity is expected to continue over the next several years.

TABLE IV-4

Comparison of Retirement Eligibility in Major Occupations in 1991 Selected Bureaus

Bureau	Percent
BPO	13.5%
BPD	12.2%
HCFA Average	7.5%
HSQB	6.0%
ORD	5.1%

Half of the regions have high percentages of supervisors and managers eligible to retire by 1997. These percentages range from 58 percent in San Francisco to 69 percent in Boston.

Given the high proportion of staff who will be eligible for retirement in the next few years, it is expected that a significant number of staff would plan to remain with the agency until eligible to retire. This is in fact the situation. Sixty-three percent of the survey respondents said they plan to remain with HCFA until retirement. This includes 72 percent of the supervisors and managers and 64 percent of the non-supervisory professional staff. Again, there are significant differences among HCFA components. Of special note is the response from OLP: only three of 30 non-supervisory respondents said they planned to remain until retirement.

One unknown regarding retention of younger staff until retirement is the effect of the Federal Employees Retirement System (FERS). Unlike the Civil Service Retirement System which it succeeded, FERS benefits are much more portable and employees will have

less incentive to stay in government for a career. Whether staff in the FERS system will actually be more highly job mobile remains to be seen. This is, of course, a question faced by most of the federal government.

HCFA'S EQUAL EMPLOYMENT OPPORTUNITY PROFILE

The HCFA staff is 76 percent white and 24 percent minority (18 percent black and 6 percent other minority). This level of minority representation in the HCFA workforce is slightly below the 1990 executive branch level of 27 percent.

The most recent HCFA Affirmative Employment Plan (AEP) available to the panel is for fiscal year 1988 through 1992, which was approved by the administrator in September 1988. The following table, based on data in the AEP, shows the distribution of professional and administrative staff by race and gender.

TABLE IV-5

EEO Profile: HCFA Professional and Administrative Staff

	White	Minority	Male	Female
GS/GM 13 and Above	87%	13%	72%	28%
GS 9-12	72%	28%	39%	61%

According to data in the plan, women and blacks are represented at rates higher than in the civilian labor force in most of the major professional occupations in the agency. White women are under-represented in one occupation -- accounting -- but, as noted above, accountants declined as a percentage of the staff in the major occupations during the 1984-1990 time period. In other major occupations, Hispanic males are under-represented in the general administration (301) occupation, and Asian males are under-represented in the general administration and program analyst (345) occupations.

The SES is 89 percent white and 80 percent male. Black males hold six percent of SES assignments. Asian Americans also hold six percent of SES assignments, divided equally between men and women.

The race and gender distribution of employee response to the survey closely paralleled the race and gender distribution of HCFA staff. The response pattern revealed no important differences by either race or sex on questions such as the adequacy of training received, use of job skills, amount of work given, opportunities for personal growth, and liking the work. As a group, females are more optimistic about their career opportunities in HCFA in terms of their ability to move to other units and their opportunities for advancement.

According to a report by HCFA's Equal Opportunity Office (EOO), the number of Equal Employment Opportunity (EEO) complaints has increased during the past two years, from 20 to 31. The fiscal year 1988-1992 AEP reports that EEO complaints were based on race/color, age, sex, national origin, reprisal and religion.

Overall, there are no major affirmative action problems evident in HCFA. One potential problem is whether HCFA can significantly improve minority and female representation at the more senior levels through internal promotions. The panel offers recommendations on this matter in the following chapter.

CONCLUSIONS AND RECOMMENDATIONS

HCFA has some understaffing problems, but these are less than 10 percent overall. There are a number of staff not performing at satisfactory levels, but the magnitude of this problem is probably not much different from other organizations of government. There are indications, however, that HCFA's failure to deal with poor performers is having an adverse impact on the morale of other staff.

HCFA has an aging workforce. A substantial percentage of the staff will be eligible to retire by 1997. In part because of a major reduction of staff levels in the early 1980s and frequent freezes on outside hiring, HCFA does not have a sufficient number of well-qualified mid-level professionals from which to develop and select future senior policy analysts, managers and executives. In the panel's view, this is a critical problem for the

organization of government that is central to the implementation of an ever increasing body of law on health care.

The panel recommends that HCFA:

- **Develop and maintain a data base on its staff.** Efforts to develop such a system have been initiated recently and the panel urges that this work be continued on a priority basis. A reliable workforce data system is an essential prerequisite to meaningful workforce planning.

- **Develop a proactive program to deal with staff performance issues.** These efforts should include increased staff training, placement of inappropriately assigned staff in positions more appropriate to their qualifications and abilities, and taking adverse action where other more positive efforts do not succeed. OHR should develop an action plan to help supervisors and managers deal with staff performance issues.

- **Develop a long-range human resource planning process.** Such a planning process, which should include senior management evaluation of progress towards accomplishing the resultant HRM plans, is essential to improve HRM in HCFA and to enable it to carry out effectively its growing responsibilities into the next century.

- **Seek authority to increase its staff levels by modest increments during the next few years as it deals with the issues mentioned in this report.** Increases of up to a total of 10 percent would appear to be reasonable to give HCFA management the resource flexibility to effectively deal with the many issues it must face, including current workload demands and requirements for strengthening the workforce potential. **The panel recommends further that the secretary of HHS, the director of OMB, and Congress consider favorably HCFA requests for staff level increases within this range.** The panel has limited its judgment on needed staffing levels to the relatively short-term future. Changed workload conditions, as well as potential productivity gains through HRM improvements in line with other panel recommendations will affect needed staffing levels in the longer term.

CHAPTER FIVE

HCFA'S HUMAN RESOURCE MANAGEMENT PROGRAMS

In this chapter, the panel examines HCFA's human resources programs and how effective these programs are in supporting the HCFA mission. The organization for HRM is described, the recruitment, equal employment opportunity, position classification and compensation, and training and career development programs are assessed, and the role of OHR is evaluated.

ORGANIZATION FOR HRM

OHR serves as the central personnel office for HCFA headquarters. OHR is a unit in the Office of Budget and Administration (OBA). The head of OBA reports to the AAM.

OHR, with a staff of 78, is responsible for traditional human resource activities: staffing, position classification, training and career development, employee services, performance management, and labor-management relations. In addition, OHR is responsible for organizational analysis and preparing program and administrative delegations of authority. Project staff interviewed the director of OHR and the senior staff who report to the director, and reviewed the HRM policy guidance issued by OHR. An organization chart for OHR is in Appendix H.

EEO and affirmative action programs are managed by EOO, which is located, organizationally, at the same level as OBA under the AAM. EOO is responsible for developing HCFA's affirmative employment programs, providing counseling and, if necessary, conducting formal hearings on discrimination complaints. Project staff interviewed the director of EOO and two senior staff.

HCFA's regional offices receive HRM support from HHS regional personnel offices (RPOs). There are 10 of these offices, one in each HHS region. HCFA regional offices are located in these same cities. The RPOs report administratively to HHS regional directors

and receive technical and human resource policy direction from the assistant secretary for personnel administration (ASPER). Project staff interviewed ASPER, most of the ASPER office directors, a number of other staff with knowledge of OHR and/or RPO operations, and four of the RPOs.

Human resource operations are carried out under the provisions of two union contracts. Central office staff are represented by American Federation of Government Employees (AFGE) Local 1923. A contract has been negotiated between the local and HCFA management. Regional staff are represented by the National Treasury Employees Union (NTEU), and under a contract between HHS and NTEU. Project staff met with three officials of AFGE Local 1923. Interviews with OHR staff and other HCFA managers did not reveal any major problems with the union contracts that inhibit sound HRM.

Receiving human resource service from two separate organizations that report to different officials creates a situation for HCFA that makes it difficult to create a unified human resource program for the agency. These difficulties are evident when the several human resource activities are assessed.

HIGHER LEVEL AGENCY REGULATIONS CREATE NO PROBLEMS

During the interviews with OHR staff members, project staff asked if Office of Personnel Management (OPM) or HHS regulations cause any problems in supporting HCFA management. OHR cited no problems. In addition, ASPER staff reported that HCFA has not raised issues about regulations interfering with their ability to carry out an effective HRM program, nor has it made any requests for exemptions from departmental or OPM regulations.

RECRUITMENT PROGRAMS FRAGMENTED

OHR's recruiting and staffing office serves approximately 2,500 staff in Baltimore and Washington. The HHS RPOs serve approximately 1,600 regional staff. Central office

and regional managers characterize recruitment as largely achieved by networking, rather than through any organized long-range recruitment campaign led by OHR or the RPOs. OHR provides no functional guidance to HCFA regional managers or to the RPOs.

OHR staff estimate that central office professional and administrative hiring is about evenly divided between entry-level and mid-career individuals. This estimate is consistent with data OHR provided on central office professional and administrative hires during 1989 and 1990. Of the 103 hires OHR identified, 49 (48 percent) were appointed at grades seven and nine. However, HCFA-wide hiring data for professional and administrative staff from 1987-1990 indicates a far heavier reliance on mid-level staff recruitment. Of 527 professional hires, 360, or 68 percent, were above grade nine. It must be noted again that the uncertain accuracy of HCFA human resource data means that these comparisons must be considered approximate.

According to interview data, the principal recruiting sources for mid-level staff are SSA for analysts and computer specialists, the Department of Defense for contracting specialists and accountants, and state agencies for nurses.

Managers report that recruitment has been hindered by the repeated hiring freezes discussed in Chapter Four. One regional manager described a typical situation. The region gets authority to hire four nurses, but before final offers can be made and accepted, another freeze is imposed. By the time the freeze is lifted, they have lost one or two of the prospective employees.

Despite these problems, senior managers, particularly in the regions, reported that they are generally able to hire good quality professional staff. One senior manager did indicate that, at times, less than the best possible candidate is hired in order to fill a job before the next freeze is imposed. The main recruitment problem in the regions is finding nurses who are comfortable with the 50 percent travel requirement. In the central office, the main recruitment problem is finding actuaries, economists, statisticians, individuals with automated data processing systems expertise, and quality clerical staff. In a number of

interviews, questions were raised about HCFA's ability to attract highly qualified laboratorians when the CLIA program is staffed.

As noted in Chapter Four, the data from the employee survey are less positive on the quality of new hires. Of the supervisors who responded to the survey, almost as many said the quality of new professional and administrative hires had deteriorated as those who said quality had improved.

One very strong recruitment effort in HCFA is the Presidential Management Intern (PMI) program. The agency has been recruiting 15 or 16 PMIs annually for the past several years. Managers are pleased with this program. Focus group discussions with new professional staff included several PMIs who were also quite positive about their experiences in the program.

Another recruitment effort that received positive manager comment is the Cooperative Education Program, known as the Co-op program. This has been a nationwide effort including universities such as UCLA, Yale, Pittsburgh, Johns Hopkins, Towson State and North Carolina-Chapel Hill. Sixteen Co-op students were hired in 1989. According to OHR, 90 percent of these students convert to permanent positions after graduation, which is consistent with the experience of other federal agencies. However, OHR officials state that in 1990, a decision was made in HCFA to count Co-op staff against the employment ceiling of individual units. As a result, requests for Co-op candidates has virtually ceased with only two hired since the change.

Conclusions and Recommendations

HCFA lacks an agency-wide coordinated recruitment program. Basically, each bureau and region proceeds independently to fill individual vacancies as they occur. OHR provides very little recruitment direction to the regional offices. Because of the uncertainty of whether they can hire and how much time they have to recruit, managers have not always conducted a broad search for the most qualified candidates. A substantial

percentage of new hires are mid-career staff. Because of past staffing practices, HCFA is now faced with a shrinking pool of high-potential people from which to draw the next round of managers and senior analysts.

In the panel's opinion, a HCFA-wide staffing strategy is clearly needed. **The panel recommends HCFA develop and operate a HCFA-wide staffing program based on the human resource plan recommended in Chapter Four.**

If it is to make a difference and increase the pool of highly qualified candidates for future management and senior analyst positions, this staffing program needs continuing senior management direction, involvement and support. It cannot be an effort viewed solely as an OHR responsibility. This recruitment effort will have to interrupt the bureaus' traditional hiring networks. Bureau managers must continue to be involved, but as a part of a coherent staffing strategy designed to meet the entire agency's long-range staffing needs.

A HCFA-wide staffing program, fully supported by senior management, is essential if HCFA is to improve staff quality, change the staff skill mix in response to program changes, and lower the average age of professional staff to provide a high-quality pool from which future senior staff will be drawn.

HCFA and HHS must find a way to sustain recruiting efforts on a continuing basis through good and bad budget years. This can be done if HCFA maintains good data on historical and projected staff losses and other needs as part of the workforce planning process recommended by the panel. Only by maintaining some recruitment continuity can HCFA build and maintain solid relationships with universities. As part of its staffing program, HCFA should continue its excellent PMI program and take steps to revitalize the Co-op program, including reversing the decision to charge staff who participate in this program against the employment ceilings of individual organizational units.

AFFIRMATIVE EMPLOYMENT PROGRAMS MUST BE PART OF STAFFING STRATEGY

The last Equal Employment Opportunity Commission review of the HCFA affirmative program was conducted in 1986. This review generally gave the agency program good marks. Relations between EOO and HCFA central office managers and OHR staff were reported to be generally positive during the interviews, though there were indications of past problems.

EOO develops the HCFA AEP. The last plan developed was for fiscal year 1988 through fiscal year 1992. HCFA management has never reached agreement with AFGE Local 1923 on this plan. The underlying issue is whether the union has a right to negotiate an affirmative action plan or to negotiate on the impact and implementation of a plan. This dispute has held up full implementation of the plan in the central office, although the EOO director indicated that much of the plan is being implemented. The NTEU has approved the plan and it is being implemented in the regional offices.

Given the nature of recruitment activities in HCFA, where much hiring is done through networking, it is difficult to assess the extent to which the AEP is guiding hiring decisions. The project staff found in its interviews that the AEP is not routinely shared with the RPOs and OHR staff do not appear familiar with plan priorities.

Conclusions and Recommendations

As the data presented in Chapter Four show, many staff in professional and administrative positions at GS-12 and below are not as well educated as higher graded staff and are not considered by senior HCFA managers to have high potential for advancement to supervisory and management positions. Also, the median age of this group is about the same as the median age of the higher graded staff. Thus, HCFA does not have a sufficient number of high quality mid-level staff from which to develop and select future senior policy analysts, managers and executives. Minorities and women are not as well represented now in the higher grades as in the lower grades. This raises a serious question about HCFA's

ability to improve minority and female representation at the more senior levels in the organization through internal promotions.

The panel recommends that HCFA, as part of its human resources planning process, assess its ability to increase minority and female representation at the management levels through promotion of present mid-level staff. If it is concluded that problems exist, targeted efforts should be developed to recruit highly qualified minority and female candidates into professional and administrative career ladder positions. This effort should be integrated into the HCFA-wide staffing program recommended in the preceding section of this chapter.

CLASSIFICATION AND COMPENSATION PROBLEMS

The personnel data reports for October 1984 and October 1990 provided to the panel show that there has been no discernible "grade creep" in HCFA, either overall or by series, over this six-year period. According to these reports, the average grade has increased by 0.44, probably caused by a decrease in clerical/technical staff as a proportion of the total workforce from 24 percent to 17.5 percent.

In 12 selected professional and administrative occupations that accounted for more than 68 percent of the total workforce in 1984, and 73 percent in 1990, the aggregate average grade increased 0.05 for the six-year period. Changes for the individual series ranged from +0.28 to -0.29. For eight of the series, the average grade decreased, for three it increased, and for one it was unchanged.

Manager Views Expressed in Interviews

Most regional managers interviewed raised no major position classification issues. Only one of the four regional administrators interviewed said classification was a problem in his operation. None of the four RPOs project staff interviewed perceived any classification problems in the HCFA regional offices.

Criticism of position classification by central office managers was more widespread. Senior managers in five bureaus expressed strong negative views. One manager said the classification system is "for the birds" in that HCFA does not pay enough for some positions and overpays for others. Another manager stated that the classification of positions in OLP puts too much emphasis on supervision and not enough on the substantive work of the position. And another manager said the inability under classification standards to credit contractor support in assigning a grade to a position contributes to overstaffing situations in order to support supervisory grades. (The OHR classification staff report that the Department of Defense has developed a supervisory classification guide that credits contractor support and that OPM is considering extending this guide to civilian agencies.)

Central office managers do not see any compensation issues that are peculiar to HCFA. In their view, the pay issues they face are the same as those faced by the federal workforce generally.

Regional manager comments on the adequacy of pay vary by region. Kansas City managers see federal salaries as quite competitive. Philadelphia managers report that federal pay is not high enough to recruit good clerical staff, program analysts or auditor candidates. Federal pay for nurses is falling below state salaries in the Atlanta region.

One issue raised by regional and central office managers is what is seen as unfairness in the Performance Management Recognition System for supervisors. The pay pool for this system is perceived to provide smaller monetary rewards for supervisors than the Employee Performance Management System allows for non-supervisory staff.

Survey Results

Two survey questions deal with position classification. The first question (number 52) asked all respondents to express agreement or disagreement with the statement that their position is accurately classified. Overall, about 23 percent of all respondents expressed disagreement. There is greater disagreement with this question by professional

and administrative non-supervisory staff than by supervisory staff:

TABLE V-1

My Position is Accurately Classified

Percent Disagreement

	Central Office	Regional Office	TOTAL
Supervisors	17%	10%	15%
Non-Supervisors	23%	24%	24%

Also, regional office supervisors express less dissatisfaction with the classification of their positions than do their central office counterparts.

For the most part, this disagreement is unevenly distributed in the agency. In the regions, staff disagreement with the grades of their positions ranges from a low of 18 percent to a high of 32 percent. Supervisory disagreement ranges from a low of zero to a high of 26 percent.

In the central office, staff disagreement is highest in OBA (28 percent), BDMS (32 percent) and the Office of the Actuary (OACT) (27 percent). The lowest levels of staff disagreement are expressed by ORD (12 percent) and OLP (13 percent) staff. Central office supervisory disagreement with the grades of their positions is more generally expressed--by about 20 percent of the supervisors in OLP, OPHC, MB, OBA, BPO, HSQB and BPD.

The second question (number 80) asked only supervisors and managers to identify from ten choices the single aspect of HRM that is the greatest problem for them. Of the 539 respondents, only six (one percent) chose position classification as their greatest problem. This does not mean that classification is not a problem for the others, only that other HRM issues are more problematic. No regional managers or supervisors chose position classification as their leading human resource problem. The six central office managers

who view classification as their major HRM problem are in four bureaus -- OBA, OACT, BPO and ORD.

One survey question (number 56) asked the degree of satisfaction with pay and a second (number 57) asked the degree of satisfaction with benefits received. Forty-two percent of all respondents reported they were dissatisfied or very dissatisfied with their pay. Thirty-five percent answered the same about their benefits.

There was little difference in the level of dissatisfaction with pay between supervisors and non-supervisory professional and administrative staff. At 39 percent for both groups, it was just slightly under the all-employee response. Similarly, 39 percent of the supervisors and 36 percent of the non-supervisory professional and administrative staff were dissatisfied with their benefits.

It should be noted that this survey was conducted before the recent pay reform legislation, which includes locality pay, became effective.

Another survey question (number 50) asked respondents whether they considered they were fairly compensated in comparison to other staff in HCFA doing comparable work. Unlike general compensation levels, internal equity is under greater agency control through the position classification process. Substantial disagreement was found on this question -- more than one-third (36 percent) of all respondents disagreed with this statement. The same level of disagreement is registered in the responses from both supervisors and non-supervisory professional and administrative staff.

The View From OHR

In contrast to the considerable dissatisfaction found in the interviews and survey, the OHR view is that the HCFA classification structure is stable, well-suited to the organization and needs very little change. As evidence of this, OHR classification staff receive only 10 or 15 requests a year to review the grades of occupied individual positions.

There have been very few classification appeals -- only five or ten in the past several years.

In OHR's experience, most of the pressure for higher grades comes from a few organizational units -- OACT, OLP and ORD. OACT, in particular, appears to be concerned about its grade structure. OACT provided project staff with an analysis of actuary grades in a number of federal agencies. This study shows that grade levels of actuaries in HCFA are among the lowest of the surveyed agencies.

One significant classification change is currently being considered by OHR, forced by a change in the OPM classification standards. As discussed above, the largest group of professional staff are classified in the program analyst series. However, OPM has recently issued a revised standard for this series that requires HCFA to assign these positions to a new series. HCFA is now examining possible alternative series for these positions. While the panel has no view on the series that would be most appropriate, it does agree with HCFA's view that a single job series should be used.

One other observation on position classification in HCFA is that there are considerable differences in the procedures used to classify positions in the central office compared to the regional offices. Further, OHR provides no substantive guidance to the regions and is largely unaware of regional classification decisions made by the RPOs.

Higher Grades for Some Non-Supervisory Professional and Administrative Staff Needed

One specific area of concern was identified in the interviews. A number of managers express the view that higher grades are needed for the top-performing non-supervisory professional and administrative staff. This view was expressed by senior managers in three of the central office bureaus and in two of the four regions in which interviews were conducted.

There are already a substantial number of non-supervisory GS-13 level positions and a small number of non-supervisory GS-14 and GS-15 level positions established in HCFA. The GS-13 positions are located in both central and regional offices; the GS-14 and GS-15 positions are all located in the central office.

Data show that between 850 and 900 of the 993 grade 13 positions are non-supervisory. There are 396 GS/GM 14 positions in HCFA. Of these, 42 (11 percent) are in the GS non-supervisory schedule. There are 180 GS/GM 15 positions; only one is in the GS non-supervisory schedule. Very few of the 14 and 15 level positions are classified based on the impact of the person on the job.

OHR has identified the need to establish career paths to the non-supervisory GS-13, 14, and 15 grades in high technology occupations for individuals who have a substantial personal impact on their position. OHR is revising the procedure for classifying these positions.

Conclusions and Recommendations

The message on classification and compensation is mixed. Given the government-wide dissatisfaction with the federal position classification system, there is less dissatisfaction in HCFA on position classification than might be expected. Overall, the grade structure appears to be appropriate for HCFA at present. However, this structure may need to be changed in the future as the nature of HCFA's tasks evolves. Further, there are bureaus where this conclusion needs to be examined by HCFA, most notably in OACT, OLP and ORD.

In addition, the panel is disturbed by the high percentage of staff who do not believe they are fairly compensated in comparison to other staff doing comparable work. It is impossible to determine whether this is caused by classification practices, by employee perceptions of performance levels of other staff, by differences in workload, or other reasons. In view of the high level of negative response to this question, the panel

recommends HCFA management examine these data in some detail and develop a plan to address particular problem areas that may be identified.

The panel believes that HCFA is giving inadequate attention to the classification of regional positions. OHR should give greater attention to the classification of regional positions to provide HCFA with an agency-wide classification program -- something it does not have now. The panel recognizes that in HHS the classification decisions for regional positions are made in the RPOs. However, the panel recommends that OHR establish a system to monitor classification decisions to ensure there is classification equity among comparable positions between regions. When problems are identified, HCFA should work with the appropriate RPOs and issue any managerial guidance needed to the HCFA regional offices.

Another question that requires attention is classification of senior non-supervisory professional and administrative positions level when a higher grade is warranted by the impact of the performance of the person on the job. The panel recommends HCFA proceed to revise the process for the classification of such positions to give greater emphasis to senior management participation -- or possibly a peer review involving outside experts -- in the decision process. Evaluation of the impact of the person on the job requires a management consensus, not one reached solely between the recommending supervisor and the position classification specialist.

TRAINING AND CAREER DEVELOPMENT NEEDS IMPROVEMENT

Interview and survey data indicate that improved training and career development programs are a major need in HCFA. The agency has no overall career development strategy and, as in other human resource areas, there is a division of responsibilities between OHR and the RPOs which has contributed to uneven attention to training and career development.

Current Training and Career Development Programs

Program training, in both central and regional offices, is basically on-the-job (OJT). Managers generally see this OJT approach as appropriate, given the varied nature of positions in HCFA. The panel agrees. However, some bureaus and offices provide this training very formally, others less so. The quality of OJT training varies from unit to unit, and staff could find no evidence of any systematic evaluation of what staff at different levels should know and what work and training experiences they should have to carry out their duties and responsibilities effectively.

Some of the bureaus are providing a structured career development program for their staff. For example, OACT has a formal program designed to train staff to pass the actuary examinations. But these clearly are exceptions to the general situation in the agency.

OHR provides limited program orientation training, primarily to central office staff. In 1989, 165 persons were trained in five courses on subjects such as Medicare contractors, the HCFA budget, hospital orientation, managed care, and the legislative process. In 1990, eight training courses were given to 1,100 staff in some of the above subjects as well as a course prepared by the Chicago Regional Office on program assessment skills for regional office analysts. Two program seminars were presented at the central office that were videotaped for general use throughout the agency.

There is no general support provided to staff -- such as nurses -- who must engage in continuing education to maintain their professional credentials. There are no HCFA standards or requirements for training staff in new responsibilities nor is there any central oversight to determine whether staff are in fact being trained to perform their duties and responsibilities.

One training effort that appears to have been quite successful is in the use of personal computers (PCs). An agency-wide training program was developed and implemented under the leadership of BDMS. Most of those interviewed in both the central

and regional offices gave high marks to the PC training that has been provided in the last few years.

As discussed in the staffing section of this chapter, HCFA has relied heavily on the promotion of clerical and technical staff to fill professional vacancies over the last decade. However, the agency does not have a formal program to determine the training and career development needs of these individuals or a systematic plan to provide the needed skills and knowledge. This means that for these individuals there is not a true upward mobility program, only a promotion program. It is the panel's view that this situation must be corrected.

Supervisory, Management and Executive Development Training

Forty hours of training is required for all new supervisors by HHS; HCFA does not require additional training. Survey results indicate that 18 percent of HCFA supervisors have not yet received any supervisory training. Fifty-six percent of HCFA supervisors said in the survey that they needed more supervisory training.

For the three-year period fiscal year 1988 through fiscal year 1990, OHR reports that six supervisory training sessions were conducted for about 100 participants. Supervisory training for regional staff is secured from outside sources such as OPM. During fiscal year 1990 and fiscal year 1991, 131 regional supervisors and managers attended or planned to attend supervisory training.

HHS has no supervisory training program; ASPER is currently looking at how it might finance such training. The RPOs provide very little training. Their training role is basically regulatory; they review training requests for conformity to law and regulation.

HCFA has a management development program for grade 13 and 14 staff. This program involves job rotation for a two-year period. While available to regional and central office staff, few regional staff have applied. The nomination rate for the program has been

declining for the past two years; this led the Training and Career Development branch of OHR to evaluate the program. It found that those on the best-qualified list for participation in the program, but who were not selected, received promotions at twice the rate of those who participated. Revision of the program, or even its possible elimination, in favor of participation in an OPM program, is now being considered by OHR.

The office of the AAO has recently initiated an effort with the HCFA regional offices to develop a competitive management training and development program to help ensure that a sufficient number of employees are prepared to assume leadership positions in the regional offices. A work group has been formed to develop this program and was scheduled to present a progress report at the April 1991 Operations Executive Conference. It is anticipated that this program will involve focused training and rotational assignments within and between regional offices and in the central office. This effort should be supported by HCFA.

There is no comprehensive executive development program in HCFA. Staff are nominated by their supervisors and selected by the agency Executive Development Council to take individual training courses provided by the Federal Executive Institute or other organizations. In fiscal year 1989, 36 individuals were selected for 19 training programs at a cost of $76,269. In fiscal year 1990, 30 individuals were selected for 17 training programs at a cost of $75,294. An SES candidate training program offered by the department was discontinued a few years ago; at this time neither the department nor HCFA has such a program.

OPM has recently approved a new training policy that will significantly increase the training requirements for supervisors and managers. When implemented, this policy will require new supervisors to receive 40 hours of training within the first six months of becoming a supervisor and an additional 40 hours of training within the first two years. In addition, all incumbent supervisors will be required to take 40 hours of continuing training every two years.

New managers will be required to receive 40 hours of training within the first six months of becoming a manager and all incumbent managers will be required to take 80 hours of continuing training every two years. SES candidates and new SES staff who did not participate in an SES candidate training program will be requried to have 160 hours of training. Eighty hours of this training must be in an off-site program such as the Federal Executive Institute. Incumbent senior executives will be required to take 80 hours of training every two years.

Training Funds Limited

The HCFA training budget for fiscal year 1991, including all types of training, provides for an average of about $336 per employee. However, there is wide variation among central office bureaus and regional offices in terms of training money available. For example, San Francisco has a $35,000 training budget, or about $233 per staff member. In contrast, New York has a $3,700 training budget or about $24 per staff member. BPO has a $33,500 training budget or about $76 per staff member, while OPHC has a $52,000 training budget which provides about $482 per staff member.

In interviews, most central office managers said that finding money for training was not a problem -- freeing up staff for training was. Regional office managers consistently said that training funds were too limited.

Limited Attention Given to Training Needs Assessment

While some individual organizations within HCFA are systematically looking at the training and career development needs of their staffs -- for example, the OACT and AAO efforts discussed above -- OHR has not taken a leadership role in determining, for the agency as a whole, what training and career development needs exist or in planning how to achieve training goals.

OHR's training branch has no overall knowledge of training money available to the

individual organizational units or how available money is spent. Its role is focused on overseeing training it provides to central office staff. The training office has virtually no knowledge of, nor is it apparently expected to have an interest in, the training situation in the regions. It is noted, however, that a member of the training office was invited to participate on the AAO work group on regional office management training and development program discussed above.

Significant Training Needs Do Exist

The survey data indicate substantial training needs exist in HCFA. Twenty-nine percent of the survey respondents disagreed with the statement that they are provided sufficient training for their current job. In the central office, 21 percent of the managers and 26 percent of the non-supervisory professional and administrative staff indicated they had not received enough training. In the regions, the disagreement was even higher with 29 percent of the managers and 42 percent of the non-supervisory professional and administrative staff replying negatively. And, as mentioned earlier, 56 percent of managers and supervisors responded in the survey that they needed additional supervisory training. About one-quarter of the supervisors said in the survey that significant retraining of their current staff is needed (12 percent) or new staff with different skills are needed (13 percent).

The written comments in the survey included a substantial number of negative comments on training and career development. One-third of the 1,009 written comments from non-supervisory professional and administrative staff and one-quarter of the 254 written comments from supervisors expressed negative views on training and career development in HCFA.

Conclusions and Recommendations

Notwithstanding the fairly general satisfaction with the current performance of HCFA staff, the panel believes that there are substantial training needs at HCFA that are

unmet. It is the panel's judgment that a systematic institutionalized training needs assessment effort is needed in HCFA. The panel recommends that HCFA undertake a comprehensive, continuing training needs assessment of the entire workforce. This assessment should examine current and projected staff skill needs.

Based on this assessment, a HCFA-wide training and career development strategy should be developed. It is clear that this career development strategy should give greater attention to training to meet the future staff needs of the agency and greater training for staff promoted from clerical or technical positions into professional or administrative jobs. Career paths also need to be developed and promoted that bridge the present central office - regional office division. It is generally recognized that the cream in an organization will not simply float to the top. Systematic actions must be taken to ensure that a cadre of talent is educated, seasoned, and prepared to assume leadership posts.

The panel recommends that, based on this strategy, HCFA should establish as a priority a strong and continuing training and career development program that is sheltered from being the first program cut when funds are reduced.

SUMMARY

HCFA has major responsibilities today and the panel anticipates that these responsibilities will increase in future years. To effectively carry out its responsibilities in the future, HCFA will need to build and maintain a highly qualified and highly motivated staff. The panel is concerned that, under its current human resource programs, HCFA will not be able to perpetuate its effectiveness into the next century.

Although HCFA needs some additional staff, priority must be given to reshaping its philosophy about human resources management. No longer can it afford ad hoc solutions. A new, revitalized HRM program should embody these crucial elements on a HCFA-wide basis:

a) Development and operation of a reliable workforce data base.

b) Human resource planning.

c) Operation of a continuing, uninterrupted outside recruitment program to improve the age, education and "high potential" profile.

d) Expanded training programs (with budgetary protection), based on a sound training needs assessment, with special emphasis on managerial and executive development.

Role of the Office of Human Resources Needs Redefinition

It is clear that OHR functions primarily in support of central office components. OHR does not provide HRM leadership or guidance to regional offices, nor does it monitor the state of personnel management in the regions. OHR also does not worry about the progression of the "best and brightest" from the regions into the top policy and management jobs of the agency. This lack of attention was evident when OHR personnel were unable to provide project staff with even the most basic information on regional personnel matters, such as recruitment numbers.

OHR staff and HHS RPOs stated in interviews that they have very little contact with each other. The RPOs receive no human resource guidance from OHR; they perform their functions in accordance with HHS human resource policies and procedures.

A second characteristic of OHR performance is that the office operates primarily as a personnel administration and regulatory control organization. A review of OHR programs and issuances shows little evidence of HRM leadership for the agency. HCFA managers consistently commented that while OHR is often viewed as supportive, it is not viewed as a proactive HRM organization. OHR is seen as basically concerned with obeying the rules rather than being innovative.

OHR is making efforts to provide greater leadership. For example, it has strengthened its national recruitment efforts. This program calls for regular contacts with

a number of schools with public health programs at institutions such as Yale and Johns Hopkins to develop a group of quality candidates. OHR then seeks to sell these candidates to the program offices rather than wait until recruitment requests are received. However, in the panel's view, such a recruitment program will not be effective without sound projections of recruitment needs and management leadership to ensure bureau and regional office participation.

Another example is in the training area. OHR has initiated its first effort to provide functional training to the regions. A pilot program has been developed with the Chicago Region. However, far greater effort is needed. Here again, senior management must make a major commitment to ensure that essential training and career development programs are developed and implemented.

As discussed earlier in this report, there are almost no meaningful data on the HCFA workforce generated on a regular basis. Some HCFA units had begun assembling data on their own. Without such data, it is no surprise that HCFA has no workforce planning system. For instance, many of HCFA's top managers expressed concerns about the aging of their staffs, but few had good data on which to base action. OHR has recognized the need for such a system and started work several months ago to develop one. This effort has been suspended pending the report on the results of this study. As stated in Chapter Four, the panel believes that a human resource planning system is vitally needed in HCFA and that work to develop and implement such a system should proceed on a priority basis. Development of such a system will require a long-term commitment.

OHR's emphasis apparently has been consistent with senior management's wishes and requirements. And in fact, some of the interview data indicates there is little desire on the part of some managers, particularly in the regions, for a more aggressive HRM program, possibly because it would limit their authority and flexibility.

However, the panel believes that HCFA cannot hope to address effectively the HRM issues facing it in the future without stronger central HRM support. This support will

require redirection of effort by OHR staff. The impetus for this effort must come from senior management; it cannot and should not start with OHR if it is to bring about sustained change in the way HCFA manages its human resources.

There is no evidence that OHR will not be responsive to more aggressive management leadership and direction. OHR appears to be a competent HRM office at what it does and the staff appear to have good technical skills.

During the course of this study, some concerns were expressed about the relatively low organizational level of OHR in the HCFA hierarchy. It is true that some federal agencies are raising the organizational level of the human resources organization as they seek to meet the demands for improved HRM. HCFA management may well consider this to be needed eventually. However, as discussed in Chapter Six, the panel believes that HCFA initially must address the need for developing long-range and continuing institutional support for HRM at the senior management levels. This is the prerequisite for meaningful organizational change. Unless such support is developed, organizational relocation of the OHR will be only a band-aid at best and, at worst, an excuse for not taking the actions necessary to develop and institutionalize this support.

In summary, the panel recommends that the OHR mission be redirected to provide HRM support for the entire agency including support for agency consideration of the long-range strategic HRM issues discussed in this report.

CHAPTER SIX

STRONG AND CONTINUING HRM LEADERSHIP ESSENTIAL

In earlier chapters, the panel discussed HCFA's mission and development, how well it is doing overall in meeting the challenge of its mission, the adequacy and character of its workforce, and its HRM organization, programs and activities.

The panel concludes that during a period when HCFA has had a tremendous growth in responsibilities, there has been some erosion in the agency's capacity to carry out those responsibilities. Without improvements in HRM that erosion will continue. Significant improvements are needed in HCFA's HRM programs to support current staff in the performance of their duties. And, more importantly, improvements are needed to insure that HCFA has a highly qualified workforce in the years ahead to carry out what will undoubtedly be programs and activities of increasing importance to the nation.

In the panel's judgment, the failure to make these improvements will not lead to a dramatic collapse as in the somewhat analogous case of a highway bridge on which needed maintenance has been too long deferred. Rather, HCFA's responsibilities will gradually be carried out less and less effectively until the lack of organizational effectiveness is generally recognized as having reached crisis proportions. At that point, reaction will likely involve reorganizing and shifting responsibilities away from HCFA, poor remedies for failure to build and maintain HCFA's institutional strength and effectiveness. Because of the role HCFA plays in an area of critical importance to the American people, national interest requires that it be a first-rate agency.

GREATER SENIOR MANAGEMENT ATTENTION NEEDED

To be a first-rate agency able to effectively meet its continuing and growing challenges, HCFA will need a cadre of employees who are well qualified and trained for their responsibilities and are highly motivated to carry out the work of the agency.

While the panel believes some staff increases are necessary, merely adding staff will be of little value. Strong and continuing actions to improve HRM programs as contemplated by other panel recommendations in areas such as human resources planning, recruitment, and training and development need to be taken to ensure that there is an adequate pool of talent to replace the current career senior staff and managers. The character of the present workforce, particularly its age distribution and the likelihood that a large proportion of experienced and relatively highly educated managers, supervisors and other senior staff will be lost through retirement in the next few years, heightens the importance of these actions.

Taking the steps necessary to assure that HCFA has an adequate workforce in the future is an extremely important responsibility of the political and career leadership of the agency. Many of the senior HCFA managers interviewed acknowledged the importance of this responsibility but were quite frustrated as to how it could be pursued. They noted that during HCFA's history, its political leadership has been mostly interested in policy matters and day-to-day operational issues. HRM, beyond basic personnel administration, has seldom been very high on the agenda. They said giving HRM priority status perhaps would have been hard to do during a period marked by strong fiscal constraints, workforce downsizing, and an increasing burden of legislative change that required continuing top level attention.

As difficult as it might be, the panel believes that the time has come when this responsibility must be given very high priority by HCFA's leadership. HCFA cannot effectively address the human resource issues facing it in the future without strong and continuing policy direction and attention from senior management, beginning with the administrator but including the full executive team. Although the panel has recommended that the role of OHR be redefined, that redefinition must be in response to needs articulated and effectively supported by the HCFA leadership for it to meet its objectives.

Need to Institutionalize Leadership Attention to Human Resource Issues

There is no one way to organize to assure that HRM will get the level and quality

of continuing attention it deserves as successive administrators take HCFA's helm. But every effort should be made to institutionalize that kind of attention in a way that fits HCFA and has a good chance of survival.

The development of an HRM strategy must be grounded in long-term considerations related to HCFA's human resources needs. It should provide the foundation for the sound development and defense of year-to-year budget requests, but must look ahead to anticipate and consider HCFA's needs much further into the future.

In the panel's view, such institutionalization must begin with certain basic actions by the current administrator. She should make clear within the HCFA organization that meeting the current and future human resource needs of HCFA is an important leadership responsibility that she intends to fulfill. She should make clear to the members of her executive team, including associate administrators and bureau and office directors, whether career or noncareer, that it is also an important responsibility of their positions and that she will expect their full support and participation in formulating and pursuing strategies for fulfilling that responsibility.

Recommendations

The panel recommends that a senior management official be charged with the responsibility for directing, on behalf of the administrator, the development of strategies and for seeing to their implementation and execution. This official should be a strong leader with a demonstrated record in management and a long-term commitment to the agency. The organizational level at which this responsibility is placed is not as important as clearly establishing within the agency the value to be placed on the HRM function. This can be done only by the administrator through continuing interest in and commitment to the subject.

The panel believes that the specific organizational placement of the official who should be charged with the responsibilities outlined above, the specific functions of the

position, and the specific relationships between the position and the rest of the HCFA organization should be determined by HCFA. The panel recommends that as a first step the administrator establish a task force broadly representative of the organization to consider, in light of this report, specific organizational and functional issues and options for the administrator's consideration. In the panel's view, this approach will result in final decisions that are more likely to enjoy a high degree of organizational acceptance and be more finely tuned to the needs of HCFA, and thus be more likely to survive changes in administration and stand the test of time.

APPENDIX A

NAPA PANEL AND PROJECT STAFF BIOGRAPHIES

NAPA PANEL MEMBERS AND PROJECT STAFF BIOGRAPHIES

Panel Members

Laurence E. Lynn Jr.*, Chair, is professor at the Graduate School of Public Policy Studies and the School of Social Service Administration at the University of Chicago. He has also served as assistant secretary, planning and evaluation, U.S. Department of Health, Education and Welfare.

David M. Bray is currently executive dean for management and administration at Harvard Medical School. Prior to that he served as the associate vice president for the Medical Center at the University of Chicago, first for business and finance, and later for hospitals and clinics. He also has held positions at the Office of Management and Budget; his last post there was as deputy associate director for economics and government.

Molly Joel Coye* is director of the divison of public health at the School of Hygiene and Public Health at Johns Hopkins University. She is former commissioner of health for the State of New Jersey and has also served as a medical investigative officer for the Public Health Service.

Merlin K. DuVal is a health consultant. After practicing surgery for approximately 20 years, he served as the founding dean of the College of Medicine, University of Arizona; president, respectively, of the National Center for Health Education, Associated Hospital Sytems, and the American Health Care Institute. He is a former assistant secretary for health at the Department of Health, Education and Welfare.

Mary Jane England* is president of the Washington Business Group on Health. Prior to that, she was vice president for medical services at Prudential Insurance Company. She also serves as the national program director of the Robert Wood Johnson Foundations' Mental Health Services Program for Youth. She is a former director of the Lucius N. Littauer Master in Public Administration Program and associate dean of the JFK School of Government at Harvard University. She is also a former commissioner of the Massachusetts Department of Social Services.

Antonio Favino is senior vice president for government program operations for Blue Cross and Blue Shield of Florida. Formerly, he served as assistant vice president for Part A and B Medicare operations for Blue Cross and Blue Shield of Greater New York. While in New York he also held positions as vice president of regular business operations and product and administration planning, respectively, as second vice president for government programs, and director of management services.

Sally H. Greenberg* is former associate director of the U.S. Office of Personnel Management for executive personnel and management development, and previously director of the Bureau of Executive Personnel of the U.S. Civil Service Commission. She has served on several Academy panels, including an evaluation of personnel operations at the Smithsonian Institution.

Lawrence S. Lewin is president, Lewin/ICF. He has had many years of consulting experience with the health care industry and has performed extensive studies on a variety of public policy issues, including the financing of indigent care and the uninsured.

Keith Weikel is senior executive vice president, Health Care and Retirement Corporation of America and former commissioner of the federal Medicaid program at the Social and Rehabilitation Service, Department of Health, Education and Welfare.

Project Staff

Don I. Wortman[*], project director, currently serves as vice president and director of federal programs at the National Academy of Public Administration. He has also served as acting administrator of the Health Care Financing Administration when it was created, and deputy commissioner and acting commissioner of the Social Security Administration. He also served as deputy director for administration at the Central Intelligence Agency. B.A. from Macalester College and Master's degree in public administration from the University of Minnesota.

Gregory J. Ahart, deputy project director, is a former assistant comptroller general for human resources at the General Accounting Office. Before that, he served as director of the human resources division and deputy director of the former civil division. B.S. in business administration from Creighton University, J.D. from Georgetown University.

Frank A. Yeager, senior research associate, has consulted with the Academy on several human resource management evaluations, including those for the Bureau of Prisons and the Smithsonian Institution. He was director of personnel management for the Department of Labor where he also served as director of information resources management, director of management policy and systems and director of audit and investigations. He holds a D.P.A. from the University of Southern California.

J. Alison Morris, research associate, has worked on Academy evaluations of the Smithsonian Institution's human resources management, the President's Commission on Executive Exchange and demonstration projects sponsored by the Small Business Administration, among others. She has also worked for the Organization Research and Analysis team of the Wyatt Company and as a consultant for the American Red Cross National Headquarters. B.A. in anthropology from Macalester College and a Master's degree in applied anthropology from the University of Maryland.

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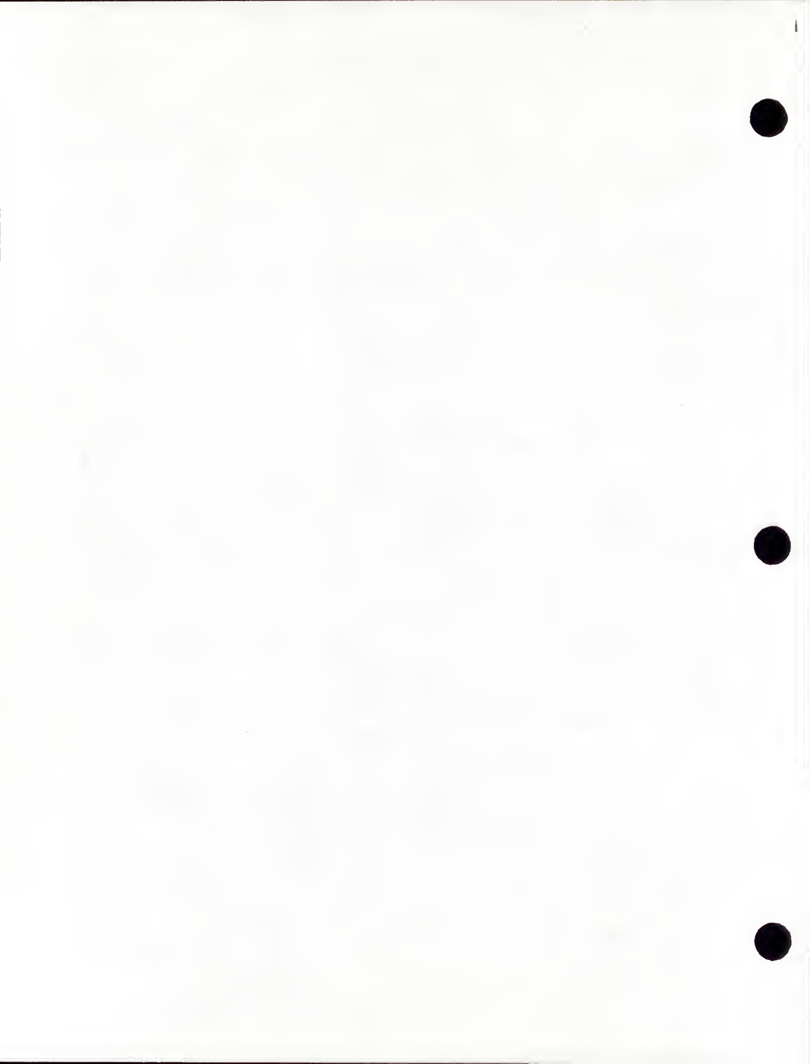
[*] Academy Fellow

APPENDIX B

LIST OF AFFILIATIONS OF THOSE INTERVIEWED
OUTSIDE HCFA



LIST OF AFFILIATIONS OF THOSE INTERVIEWED OUTSIDE HCFA

Contractors

Blue Cross Blue Shield Association

Federal Government

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Legislation

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Management and Budget

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Personnel Administration

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services, Office of the Inspector General

U.S. General Accounting Office

U.S. House of Representatives, Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies

U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment

U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health

U.S. Office of Management and Budget

U.S. Office of Personnel Management

U.S. Senate, Committee on Appropriations, Subcomittee on Labor, Health and Human Services, Education and Related Agencies

U.S. Senate, Committee on Finance

National Associations

American Health Care Association

American Hospital Association

American Medical Association

American Osteopathic Hospital Association

American Public Welfare Association

Association of Health Facility Survey Agencies

Association of State and Territorial Health Officials

Federation of American Health Systems

National Association for Home Care

National Conference of State Legislatures

National Governors' Association

National Commissions

Physician Payment Review Commission

Prospective Payment Review Commission

State Licensure and Certification Agencies

Alabama

California

Georgia

Indiana

Kansas

Kentucky

Michigan

Missouri

Pennsylvania

State Health Facilities/Health Care Associations

California

Indiana

Louisiana

Texas

State Medicaid Agencies

District of Columbia

California

Georgia

Kansas

State/Regional Hospital Associations

Colorado

Illinois

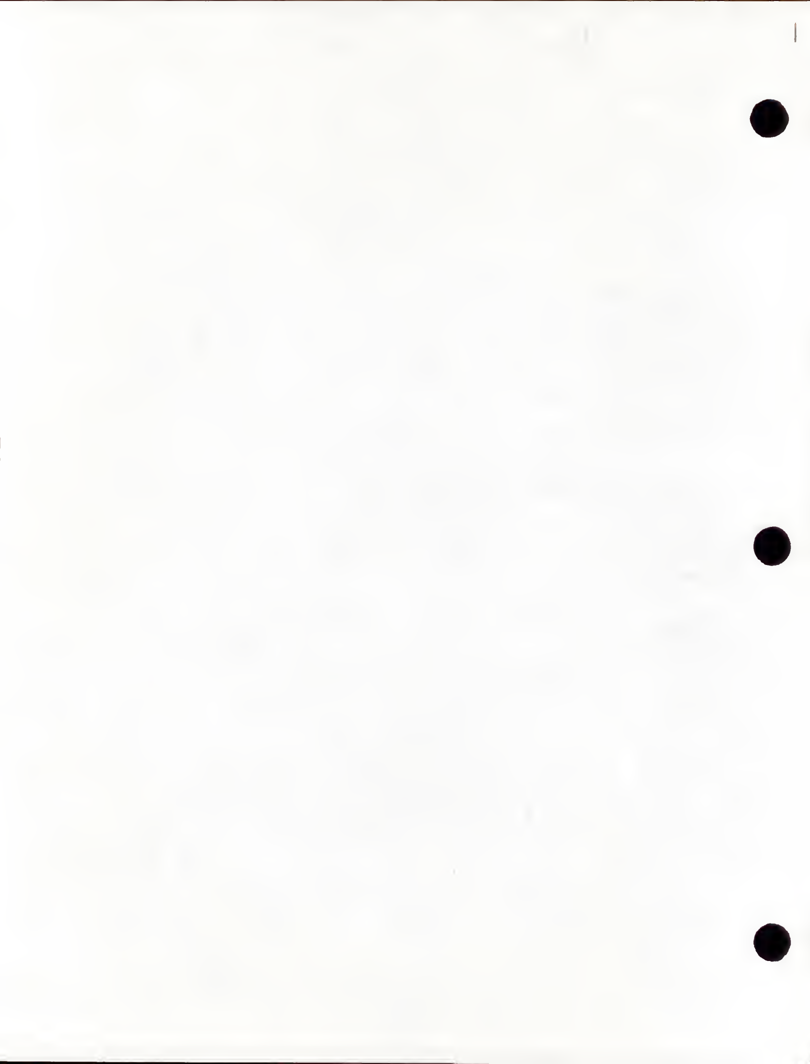
Kansas City Area

Louisiana

Maryland

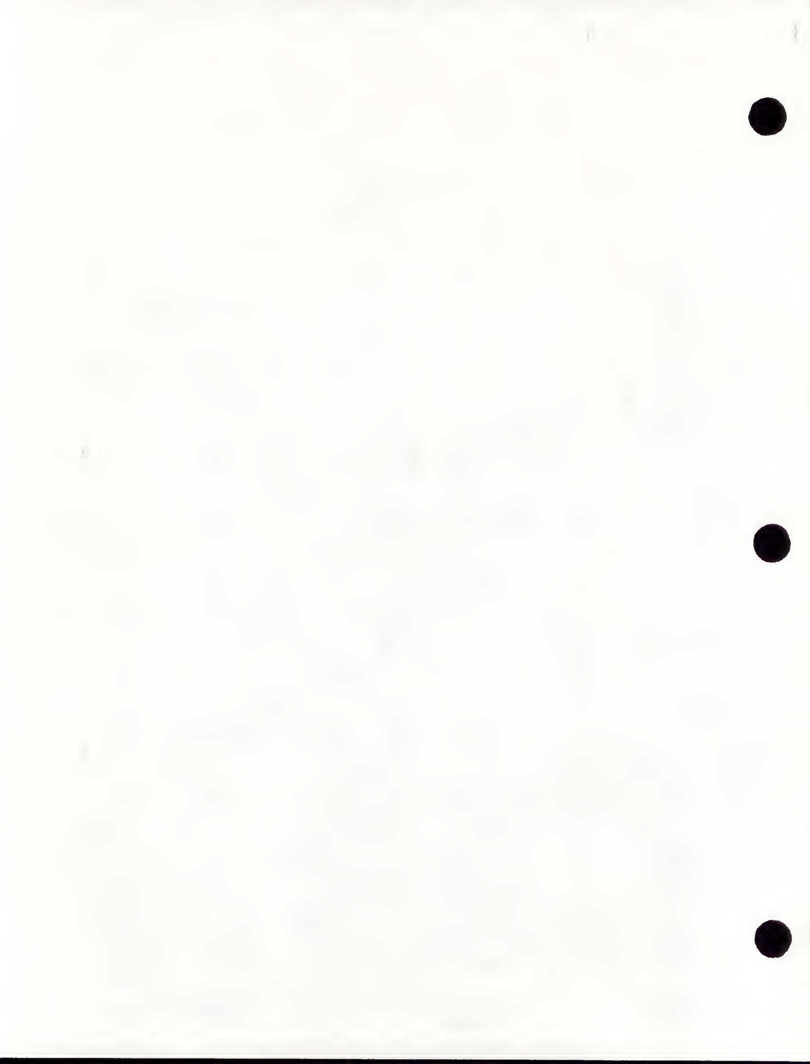
Michigan

Texas



APPENDIX C

EMPLOYEE SURVEY RESPONSES



HCFA Staff Survey *

Instructions: Except where otherwise indicated, circle only one answer for each question.

Part I — DEMOGRAPHICS

The following information is needed for statistical analysis of the data. All of your responses are strictly confidential. Individual responses will not be seen by anyone in HCFA or HHS. Reported data and results of the analysis will be presented so that no individual can be identified.

1. What is your pay category?

%	Response
81.4	1. GS
15.0	2. GM
1.0	3. SES
2.3	4. PHS Commissioned Corps
.3	5. Other (Please specify________________)

2. What is the classification series of your present position?

%	Response	%	Response
2.0	1. 101	3.4	9. 501
23.3	2. 301	5.6	10. 510
2.2	3. 303	1.5	11. 511
[illegible].4	4. 318	3.5	12. 600 series (e.g. 600, 630)
[illegible].0	5. 334	1.1	13. 1101 or 1102
2.2	6. 340	2.7	14. 110, 1510, 1515, 1529, or 1530
4.3	7. 343	5.9	15. All other professional and administrative series
25.3	8. 345	2.7	16. All other clerical, technical, and wage grade series

3. What is your present grade or rank?

%	Response
1.6	1. GS 1-4 or equivalent
13.8	2. GS 5-8 or CC 0-1, 0-2
38.3	3. GS 9-12 or CC 0-3, 0-4
45.3	4. GS/GM 13-15 or CC 0-5, 0-6
.9	5. Above GS/GM 15 or CC 0-7, 0-8, 0-9

4. What is your age?

%	Response	Response	%
3.1	1. 24 or younger	4. 40-49	45.7
4.1	2. 25-29	5. 50-54	13.5
22.2	3. 30-39	6. 55 or above	11.3

5. What is your length of service (civilian and military) with the federal government?

%	Response
1.7	1. Less than one year
9.0	2. 1 through 4 years
6.5	3. 5 through 9 years
40.9	4. 10 through 19 years
[illegible].8	5. 20 through 29 years
6.2	6. 30 years and over

6. What is your length of service with HCFA?

If you were assigned to HCFA through reorganization in 1977 or subsequently, include service in the predecessor organization in determining length of HCFA service. (For example, if you joined HCFA by transfer of the Bureau of Health Insurance from SSA, length of service should include service in BHI).

Response	%
1. Less than one year	4.2
2. 1 through 4 years	20.8
3. 5 through 9 years	11.4
4. 10 through 19 years	48.5
5. 20 through 29 years	13.9
6. 30 years and over	1.1

7. What is the location of your current permanent duty station?

Response	%
1. Baltimore	57.4
2. Washington	4.4
3. Regional Office	38.2

8. Are you a manager or supervisor?

Response	%
1. Yes	17.3
2. No	82.6

9. What is your sex?

Response	%
1. Male	45.8
2. Female	54.2

10. What do you consider your principal ethnic or racial background?

Response	%	Response	%
1. American Indian	.5	4. Hispanic	2.0
2. Black	17.7	5. Asian American	1.8
3. White	76.5	6. Other	1.5

Part II — Employment and Education

11. How did you join HCFA (or the organization that was reorganized into HCFA)?

Response	%
1. Competitive civil service appointment (except PMI/MI)	41.3
2. Presidential Management Intern (PMI) or Management Intern (MI) Program	3.0
3. Coop program	1.5
4. Transfer from a HHS agency as an individual (not through reorganization)	30.2
5. Transfer from a non-HHS federal agency	12.0
6. Excepted appointment	3.0
7. Commissioned Corps assigment	1.8
8. Other (Please specify________________)	7.1

* Numbers represent the percentage distribution of responses to each question

12. What kind of position did you hold when you first entered HCFA (or the organization that was reorganized into HCFA)?

52.3 1. Professional
6.3 2. Administrative
12.1 3. Technical
28.6 4. Clerical
.7 5. Wage grade

13. What was the highest level of education you had completed when you *first* joined HCFA (or the organization that was reorganized into HCFA)?

.9 1. Some high school
14.5 2. High school diploma or equivalent
23.4 3. Some college or technical education beyond high school
1.6 4. Graduate of technical education program
27.6 5. Bachelors degree
10.8 6. Some graduate study
17.4 7. Masters degree
3.7 8. Professional degree or doctorate (check all that apply)
- JD or LLB 44.7
- MD 7.4
- PhD 39.4
- Other earned doctorate 7.4

.1 9. Post-doctoral work

14. Have you completed any further formal education *since* you first joined HCFA (or the organization that was reorganized into HCFA)?

34.5 1. Yes
65.5 2. No (Skip to Question 15)

If you answered YES to question above, what is the highest level of education you have now completed?

.8 1. Some high school
40.9 2. High school diploma or equivalent
3.4 3. Some college or technical education beyond high school
11.0 4. Graduate of technical education program
23.3 5. Bachelors degree
16.3 6. Some graduate study
3.8 7. Masters degree
.5 8. Professional degree or doctorate (check all that apply)
- JD or LLB 59.3
- MD 33.3
- PhD 7.4
- Other earned doctorate

9. Post-doctoral work

15. In what organizational unit are you currently assigned?

A. Headquarters Assignments: *If your specific unit is not listed, circle the number of the unit to which your unit reports.*

Unit	%
01. Office of the Administrator	.8
02. Office of Legislation and Policy	1.5
03. Office of Prepaid Health Care	2.5
04. Office of Executive Operations	.9
05. Medical Bureau	4.9
06. Office of the Associate Administrator for Communications	1.0
07. Office of the Associate Administrator for Management	1.5
08. Office of Budget and Administration	8.3
09. Bureau of Data Management and Strategy	9.4
10. Office of the Actuary	1.7
11. Office of the Associate Administrator for Operations	1.1
12. Bureau of Program Operations	10.9
13. Health Standards and Quality Bureau	5.6
14. Office of the Associate Administrator for Program Development	1.3
15. Bureau of Policy Development	6.4
16. Office of Research and Administration	3.5

B. Regional Assignments: *Indicate (1) your region; and (2) your unit*

Region:

%	Region	Region	%
3.7	17. Boston	22. Dallas	4.0
4.1	18. New York	23. Kansas City	3.0
4.1	19. Philadelphia	24. Denver	2.9
4.6	20. Atlanta	25. San Francisco	4.3
5.5	21. Chicago	26. Seattle	2.3

Unit:
- Division of Health Standards and Quality 28.8
- Division of Medicare 36.8
- Division of Medicaid 27.5
- Office of the Regional Administrator 6.9

16. How long have you worked in the headquarters organization or region checked in question 15?

1. Less than one year 8.0
2. One year to five years 27.6
3. More than five years 64.4

17. Since 1977, have you been reassigned or promoted from one of the headquarters units listed (or predecessor units not listed in question 15) or regions to another of the listed units (or predecessor units, such as movement to or from the Bureau of Quality Control) or regions?

NOTE: Do not count movement within a listed headquarters unit or within a region.

1. Yes 27.1
2. No (GO TO Question 20) 72.8

18. Please circle the numbers of *all* the other units in which you have worked since 1977.

If the specific organizational unit in which you worked is not listed, circle the number of the higher level organizational component in which the unit was located.

01. Office of the Administrator
02. Office of Legislation and Policy
03. Office of Prepaid Health Care
04. Office of Executive Operations
05. Medical Bureau
06. Bureau of Quality Control
07. Office of the Associate Administrator for Communications
08. Office of the Associate Administrator for Management
09. Office of Budget and Administration (or Office of Management and Budget)
10. Bureau of Data Management and Strategy
11. Office of the Actuary
12. Office of the Associate Administrator for Operations
13. Bureau of Program Operations
14. Health Standards and Quality Bureau
15. Office of the Associate Administrator for Program Development
16. Bureau of Policy Development (or Bureau of Eligibility, Reimbursement and Coverage)
17. Office of Research and Demonstrations
18. Boston Regional Office
19. New York Regional Office
20. Philadelphia Regional Office
21. Atlanta Regional Office
22. Chicago Regional Office
23. Dallas Regional Office
24. Kansas City Regional Office
25. Denver Regional Office
26. San Francisco Regional Office
27. Seattle Regional Office

28. If the unit(s) no longer exist(s) please list: ______________________

____

____

19. What was the reason for the *last* organizational change you made?

1. Reorganization
2. Selected for position in another unit and moved by reassignment or promotion

20. During a typical week, approximately what percent of your time is spent working with each of the following groups?

1. Staff in own unit ___%
2. Staff in other HCFA bureaus ___%
3. Staff in HHS ___%
4. Staff in other federal agencies ___%
5. Staff in Congress ___%
6. Staff in contractor organizations ___%
7. Staff in public interest groups ___%
8. General public, including media ___%

100%

21. What is the earliest date by which you are eligible to retire?

1. By December 31, 1991 7.8
2. By December 31, 1994 8.8
3. By December 31, 1997 11.6
4. By December 31, 2000 12.7
5. By December 31, 2005 25.5
6. By December 31, 2010 13.3
7. After December 31, 2010 20.3

22. Do you currently plan to remain with HCFA until you are eligible for federal retirement?

1. Yes (GO TO #23; SKIP #24) 63.2
2. No (GO TO #24; SKIP #23) 9.8
3. Do not know (GO TO #25) 26.9

23. *If you are eligible to retire by December 31, 1997,* **and answered YES to #22, when do you currently plan to retire?**

1. As soon as you become eligible 21.2
2. Later, when you have a more attractive employment alternative 5.2
3. Later, when you no longer plan to work 11.9
4. Do not know 18.9
5. Not applicable (not eligible until after December 31, 1997) 42.7

24. *If you answered NO to question #22,* **when do you plan to leave HCFA?**

1. As soon as possible 23.2
2. Within the next six months 5.7
3. Within the next two years 17.3
4. More than two years from now 13.9
5. Do not know 40.0

Part III — JOB EXPERIENCES

How much do you agree with the following statements about your work experience? Please check the column corresponding to the answer that best describes your opinion.

	Strongly Agree (1)	Generally Agree (2)	No opinion (3)	Generally Disagree (4)	Strongly Disagree (5)
25. I am provided sufficient training for my current position.	15.5	49.8	5.7	21.4	7.6
26. For the most part, the co-workers in my unit are cooperative.	34.6	57.7	3.1	3.7	.9
27. For the most part, the co-workers in other HCFA units with which I work are cooperative.	17.2	73.2	4.7	4.2	.7
28. I am satisfied with my immediate supervisor's technical abilities.	37.5	39.3	8.7	8.6	6.0
29. I am satisfied with my immediate supervisor's supervisory/managerial abilities.	26.4	37.2	10.5	14.3	11.6
30. I am satisfied with my supervisor's efforts to relate my work to the overall objectives of HCFA.	27.0	39.5	14.7	12.2	6.6
31. My unit has too many staff for the work assigned.	3.3	5.7	9.6	29.8	51.6
32. Staff with whom I work are generally well qualified for the duties they are assigned.	18.0	58.6	9.6	11.4	2.4
33. Staff with whom I work are generally industrious and conscientious.	22.4	57.1	10.6	7.8	2.1
34. My job makes good use of my skills and abilities.	21.1	49.2	6.4	15.8	7.5
35. My workload is excessive.	21.0	30.8	16.7	26.7	4.7
36. I like my work.	28.9	48.7	9.4	8.6	4.4
37. My unit has enough staff to do the job right and on time.	9.0	31.3	8.9	28.8	21.9
38. I am often required to get approval for decisions I should be able › make myself.	12.5	24.0	16.5	37.5	9.6
39. I am not given enough work.	4.3	7.0	8.3	35.5	45.0
40. I believe I would have an opportunity to work in other units in HCFA if I wished to.	12.7	37.1	17.1	18.5	14.7
41. I am satisfied with the adequacy of the feedback I get about my performance.	14.2	47.2	9.4	17.8	11.4
42. My performance standards cover the most important parts of my job.	15.9	53.1	10.2	14.0	6.8
43. I never seem to have enough time to get the work done.	14.0	28.4	14.3	35.8	7.6
44. My superiors make prompt decisions on work issues and do not delay my completion of assignments.	12.4	43.9	12.9	19.3	11.5
45. The people I work with generally do a good job.	20.5	64.7	8.7	5.3	.8
46. I am interested in work assignments in other HCFA units.	20.2	32.2	23.9	16.9	6.8
47. HCFA staff have the reputation of being competent and professional.	14.8	50.7	20.7	10.1	3.6
48. The responsibilities of the unit in which I am currently working do not conflict with those of other HCFA units.	18.7	50.2	14.8	12.5	3.9

	Strongly Agree (1)	Gene-rally Agree (2)	No opinion (3)	Gene-rally Dis-agree (4)	Strongly Dis-agree- (5)
49. HCFA senior management keeps employees well informed about developments in HCFA that affect their work and/or careers.	5.8	30.1	14.3	28.8	21.0
50. I am fairly compensated in comparison to other staff at HCFA doing comparable work.	6.3	42.5	15.2	21.1	14.9
51. My opportunities for advancement to greater responsibility are good.	4.6	23.1	14.1	28.8	29.4
52. My position is accurately classified.	11.9	48.8	15.8	13.8	9.6
53. I would file a discrimination complaint or grievance if I felt I had been discriminated against.	22.0	31.0	21.6	17.9	7.6
54. I know who to contact in order to file a discrimination complaint or grievance.	30.6	44.8	9.0	10.5	5.1

Part IV — MEASURES OF JOB SATISFACTION

How satisfied are you with the following aspects of your job? Please check the column corresponding to the answer that best describes your opinion.

	Very Satis-fied (1)	Gene-rally Satis-fied (2)	No opinion (3)	Gene-rally Dissatis-fied (4)	Very Dis-satis-fied (5)
55. The worthwhile nature of the work	28.3	52.8	6.0	9.5	3.5
56. The pay I receive	9.1	43.9	5.4	27.2	14.3
57. The benefits I receive	11.3	47.7	5.8	24.5	10.7
58. The job security I have	25.0	57.9	7.5	6.9	2.7
59. The working environment	9.3	46.7	7.7	23.7	12.7
60. The attitude of the public toward HCFA	2.9	31.0	29.0	28.0	9.1
61. The amount of stress	3.2	38.8	16.7	27.2	14.0
62. The work habits and attitudes of my co-workers	9.0	54.1	12.3	18.2	6.4
63. My opportunities for personal growth and development	6.5	34.2	11.7	28.5	19.1
64. My relationship with my immediate supervisor	29.6	45.4	8.2	9.3	7.6
65. HCFA relationships with private or non-federal government organizations with which HCFA works	7.1	49.9	29.9	10.1	3.0
66. The attitude of the public toward Federal employees	1.3	13.1	15.9	41.4	28.3
67. The challenge of my work	18.1	54.1	7.7	14.0	6.0
68. My ability to do quality work	40.1	49.8	2.6	5.6	1.8
69. My understanding of how the work of my unit contributes to overall HCFA objectives	27.2	52.4	9.3	8.2	3.0

Part V — SUPERVISORY ISSUES

If you are NOT a manager or a supervisor, please SKIP questions #70 through #85 and GO TO # 86

70. How long have you been a supervisor or a manager?

1. Less than one year 6.6
2. One through five years 33.0
3. Six through ten years 22.0
4. More than ten years 38.3

71. Do you have adequate authority to carry out your supervisory responsibilities?

1. Yes 71.4
2. No 28.6

72. Have you had supervisory training since being appointed a supervisor?

1. Yes 82.1
2. No (GO TO #74) 17.9

73. If you answered YES to question #72, how helpful was the supervisory training you received?

1. Very helpful 28.3
2. Somewhat helpful 57.1
3. Not particularly helpful 14.5

74. Do you feel a need for additional supervisory or management training?

1. Yes 55.6
2. No 44.4

75. In a typical week, approximately what percent of your working time do you devote to the following activities?

1. Meeting with superiors ____%
2. Giving assignments to staff, monitoring work progress, and reviewing staff work products ____%
3. Dealing with staff human relations problems ____%
4. Staff evaluation and performance feedback ____%
5. Meetings with people outside unit ____%
6. Performing non-supervisory technical work of unit ____%
7. Administrative paperwork ____%
8. Other (________________) ____%

100%

76. What is the more important part of your responsibilities, supervision or technical expertise? (Circle the statement which most nearly reflects your opinion.)

1. Supervision of staff is far more important 22.2
2. Supervision of staff is somewhat more important 18.3
3. Supervision of staff and technical contribution are about equal 38.3
4. Technical contribution toward work of unit is somewhat more important 12.8
5. Technical contribution toward work of unit is far more important 8.5

77. Over the period of time you have been a supervisor, the overall quality of new clerical and technical employees has:

1. Remained the same 28.4
2. Improved 18.7
3. Deteriorated 52.9

78. Over the period of time you have been a supervisor, the overall quality of new professional and administrative employees has:

1. Remained the same 38.8
2. Improved 32.6
3. Deteriorated 28.5

79. Compared to other units in HCFA, is your unit treated fairly in allocation of personnel ceiling?

1. Yes 43.8
2. No 56.2

80. What single aspect of personnel management is the greatest problem for you as a manager (Circle only one)

1. Recruitment and staffing 27.6
2. Staff training 2.6
3. Performance appraisal 20.2
4. Position classification 1.1
5. Awards and recognition 3.3
6. Discipline 3.7
7. Labor management relations 1.9
8. Dealing with poor performance 21.3
9. Other (________________) 5.4
10. Have no difficulties with personnel management 12.8

81. When you have a difficult personnel management problem, needed advice and assistance is:

1. Readily available to you 58.5
2. Available to you with some difficulty 31.3
3. Quite difficult to obtain 10.2

82. The number of professional and administrative staff in the unit you supervise is:

1. In excess of what is needed to do the work assigned to the unit — 1.8
2. About the right number for the work assigned to the unit — 28.8
3. Inadequate — up to 10% staff increase is needed for the work assigned to the unit — 31.2
4. Very inadequate — more than a 10% staff increase is needed for the work assigned to the unit — 38.2

83. Do you have an adequate number of clerical and technical staff in the unit you supervise?

1. Yes 33.3
2. No 66.7

84. How would you rate the work performance of the professional and administrative staff in the unit you supervise?

1. Generally good to excellent — 50.7
2. Good for the most part but there are some marginal or poor performers — 41.1
3. Adequate to good but there are too many marginal or poor performers — 7.0
4. Generally not up to par — 1.1

85. How would you rate the knowledge and skills of the professional and administrative staff in the unit you supervise?

1. For the most part, they are appropriate for the work assigned to the unit — 74.6
2. Significant retraining and skills upgrading of current staff is needed — 12.0
3. New staff are needed with knowledge and skills not possessed by the current staff in the unit; retraining current staff not likely to be effective — 13.3

PLEASE TURN TO THE LAST PAGE

PART VI – OTHER ISSUES

86. In the space below, please provide any additional comments you may have related to your job satisfaction and ability to perform to the best of your ability

Please see Appendix D for an analysis of the written comments.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

COMPARISON OF SUPERVISORY (S) AND NON-SUPERVISORY (NS) RESPONSES TO SELECTED SURVEY QUESTIONS

	% Strongly agree	% Agree	% No Opinion	% Disagree	% Strongly Disagree
Q.25. Provided sufficient training					
S	18	54	4	18	6
NS	13	48	6	24	9
Q.26. Unit co-workers cooperative					
S	34	63	1	3	0
NS	35	57	3	4	1
Q.27. Other co-workers cooperative					
S	15	77	1	6	0
NS	16	74	5	4	1
Q.28. Supervisor good technically					
S	38	39	8	10	6
NS	36	40	9	9	7
Q.29. Supervisor good managerially					
S	25	39	9	17	10
NS	25	36	11	15	13

	% Strongly agree	% Agree	% No Opinion	% Disagree	% Strongly Disagree
Q.30. Supervisor relates work to overall objectives					
S	29	42	11	12	6
NS	25	39	16	13	8
Q.31. Too much staff in unit					
S	2	3	3	23	70
NS	3	6	10	32	49
Q.32. Staff well qualified					
S	16	63	5	15	2
NS	17	58	10	12	3
Q.33. Staff industrious					
S	22	65	6	7	0
NS	23	57	10	8	3
Q.34. Job makes good use of skills					
S	27	56	3	10	4
NS	19	50	7	16	8
Q.35. My workload excessive					
S	34	34	9	22	2
NS	18	30	19	28	5

	% Strongly agree	% Agree	% No Opinion	% Disagree	% Strongly Disagree
Q.36. Like my work					
S	36	48	5	8	3
NS	27	50	10	9	5
Q.37. Unit has enough staff					
S	5	25	3	31	36
NS	9	32	9	30	20
Q.38. Should make more decisions myself					
S	15	26	7	41	11
NS	12	24	17	38	9
Q.39. Not given enough work					
S	3	3	3	29	63
NS	5	7	9	38	41
Q.40. Could get work in other units					
S	14	42	12	22	11
NS	12	37	18	18	15
Q.41. Get adequate performance feedback					
S	11	49	7	21	11
NS	13	48	10	18	12

	% Strongly agree	% Agree	% No Opinion	% Disagree	% Strongly Disagree
Q.42. Performance standards good					
S	14	58	7	13	8
NS	14	53	11	15	7
Q.43. Not enough time to get work done					
S	23	35	7	31	3
NS	12	28	16	36	8
Q.44. Superiors make prompt decisions					
S	12	52	7	18	11
NS	11	42	13	21	13
Q.45. Co-workers do good job					
S	20	70	5	4	0
NS	19	65	10	6	1
Q.46. Interested in working in other units					
S	16	33	20	25	7
NS	20	32	25	16	7
Q.47. HCFA staff reputed competent					
S	16	56	14	11	3
NS	13	49	22	11	4

	% Strongly agree	% Agree	% No Opinion	% Disagree	% Strongly Disagree
Q.48. Unit responsibilities don't conflict with those of other units					
S	24	53	5	14	4
NS	17	51	16	13	4
Q.49. Senior management keeps employees informed about developments					
S	4	37	11	30	19
NS	5	27	14	31	23
Q.50. Compensated fairly in relation to other HCFA staff					
S	6	49	11	23	12
NS	6	43	15	21	15
Q.51. Good opportunity for advancement					
S	4	26	15	33	23
NS	4	23	14	29	30
Q.52. Classification accurate					
S	17	60	8	8	7
NS	11	49	17	15	9
Q.53. Would file complaint if had cause					
S	12	31	20	27	11
NS	22	32	21	19	7
Q.54. Know where to file complaint					
S	33	48	7	9	3
NS	29	46	9	11	5

	% Very Satisfied	% Satisfied	% No Opinion	% Dis-satisfied	% Very Dis-satisfied
Q.55. Worthwhile nature of work					
S	41	49	3	6	2
NS	25	53	6	11	4
Q.56. My pay					
S	10	48	3	29	10
NS	10	46	6	26	13
Q.57. My benefits					
S	11	48	4	28	10
NS	11	47	6	25	11
Q.58. My job security					
S	30	60	4	3	2
NS	25	57	8	8	3
Q.59. My working environment					
S	9	49	6	24	12
NS	8	45	8	26	14
Q.60. Public attitude toward HCFA					
S	2	32	18	37	12
NS	2	30	30	28	9

	% Very Satisfied	% Satisfied	% No Opinion	% Dis-satisfied	% Very Dis-satisfied
Q.61. Amount of stress					
S	2	34	11	34	20
NS	3	41	17	27	13
Q.62. Co-workers' attitudes					
S	8	65	7	17	3
NS	8	53	13	18	7
Q.63. Opportunities for personal growth					
S	7	42	11	29	12
NS	6	33	13	30	20
Q.64. Relationship with immediate supervisor					
S	27	44	7	12	10
NS	28	46	8	10	8
Q.65. HCFA relationship with outside organizations					
S	6	61	19	12	3
NS	7	50	29	11	4
Q.66. Public attitude toward federal employees					
S	0	10	6	45	39
NS	1	11	16	43	29

	% Very Satisfied	% Satisfied	% No Opinion	% Dis-satisfied	% Very Dis-satisfied
Q.67. Challenge of my work					
S	30	57	3	8	3
NS	16	55	8	15	6
Q.68. My ability to do quality work					
S	38	51	2	7	2
NS	38	52	3	6	2
Q.69. My understanding of unit contribution to HCFA objectives					
S	37	54	3	3	2
NS	24	52	11	10	4

APPENDIX D

HCFA STAFF SURVEY WRITTEN COMMENTS ANALYSIS

HCFA STAFF SURVEY
ANALYSIS OF WRITTEN COMMENTS

At the end of the survey, employees were invited to provide any comments that were related to their job satisfaction and ability to perform to the best of their ability. About 45 percent (1,458) of those who responded to the survey also wrote comments. Some were brief; others were several pages long. Every comment was read at least once by the project staff.

Project staff coded the comments originally into 44 categories which were defined based on a reading of a sample of comments. After they coded all the comments and received an initial frequency distribution, the staff collapsed the categories into 12 broader ones. An "other" category was retained for responses too unique to be classified into a larger category.

The categories that emerged, with a brief explanation of the kinds of comments that fit under them, are listed below. Note: The numbers reflect the number of cases, or respondents, who wrote about a particular subject, not the total number of comments about a subject.

Descriptions of Categories Used to Code Written Comments

Category	Description
Management: (645, 44.2%)	Managers too technical; don't give enough feedback; poor decision-making skills; HCFA mission/goals unclear.
Training & Career Development: (487, 33.4%)	Lack of promotional and advancement opportunities; need for more training; need for more cross-training/rotations.
Merit/Discrimination: (346, 23.7%)	Politicization of career and non-career positions; pre-selections for promotions; nepotism; favoritism; discrimination based on race, sex, age, including reverse discrimination.
Staffing: (338, 23.2%)	Need for influx of new people; unbalanced staffing levels; not enough clerical support; recruitment problems.
Other: (292, 20%)	Contractors are overused, poorly monitored, overpaid, unqualified; against possible move to Baltimore City.
Poor Morale: (256 17.5%)	Too much work; unappreciated; bashing of federal workers; looking for early out or another job.

Pay/Classification Benefits: (249, 17.1%)	Too low graded; no distinction in work at different grade levels; inadequate pay; deterioration of benefits package.
Administrative: (220, 15.1%)	Poor physical environment in which to work; inadequate funds for travel, etc.; too much paperwork; too many petty rules.
Poor Performance: (174, 11.9%)	Poor performers get tolerated while good performers get more to do; co-workers unqualified.
Positive Morale: (167, 11.4%)	Good work atmosphere; pride in work; work is important; good supervisors.
Personnel Systems: (144, 9.9%)	Problems with the rating system, favoritism, frustration with bonus distribution.
Communication: (107, 7.3%)	Poor communication from leadership/managers to staff and from central office to regions; manuals/guidance not current.
Deadlines: (72, 4.9%)	Frustrated by deadlines; can only deal with crises; focus is on finishing work without regard to quality.

Distribution of Comments by Type of Employee

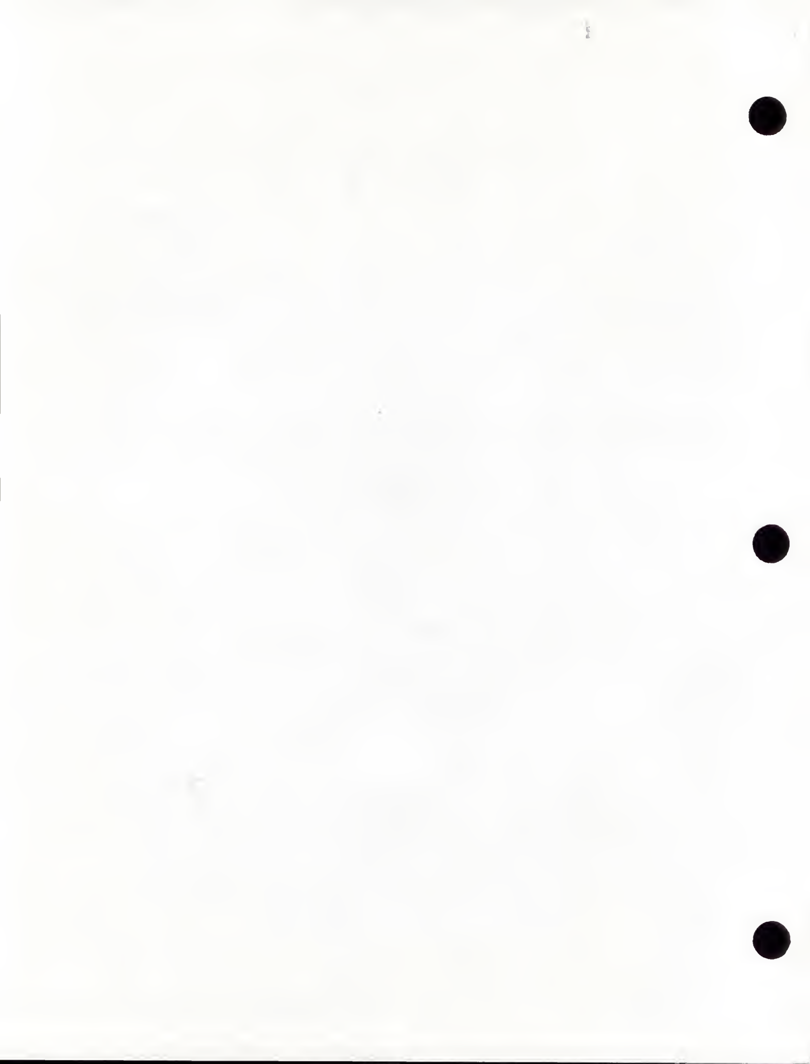
	Clerical/ Technical		Professional/Admininstrative Non-Supervisory		Supervisory	
	#	%	#	%	#	%
Personnel Systems	15	11.7	85	8.4	41	16.1
Poor Performance	5	3.9	113	11.2	47	18.5
Management	40	31.3	482	47.8	98	38.6
Staffing	9	7.0	196	19.4	122	48.0
Training-Career	58	45.3	339	33.6	65	25.6
Deadlines	1	.8	46	4.6	24	9.4
Administrative	5	3.9	169	16.7	41	16.1
Communication	1	.8	82	8.1	18	7.1
Pay-Class	36	28.1	162	16.1	38	15.0
Poor Morale	20	15.6	187	18.5	40	15.7
Merit-Discrimination	30	23.4	267	26.5	34	13.4
Positive Morale	23	18.0	114	11.3	22	8.7
Other	12	9.4	209	20.7	64	25.2
TOTAL CASES:	128		1,009		254	
TOTAL COMMENTS:	255		2,451		654	

APPENDIX E

ENACTED LEGISLATION AFFECTING HFCA

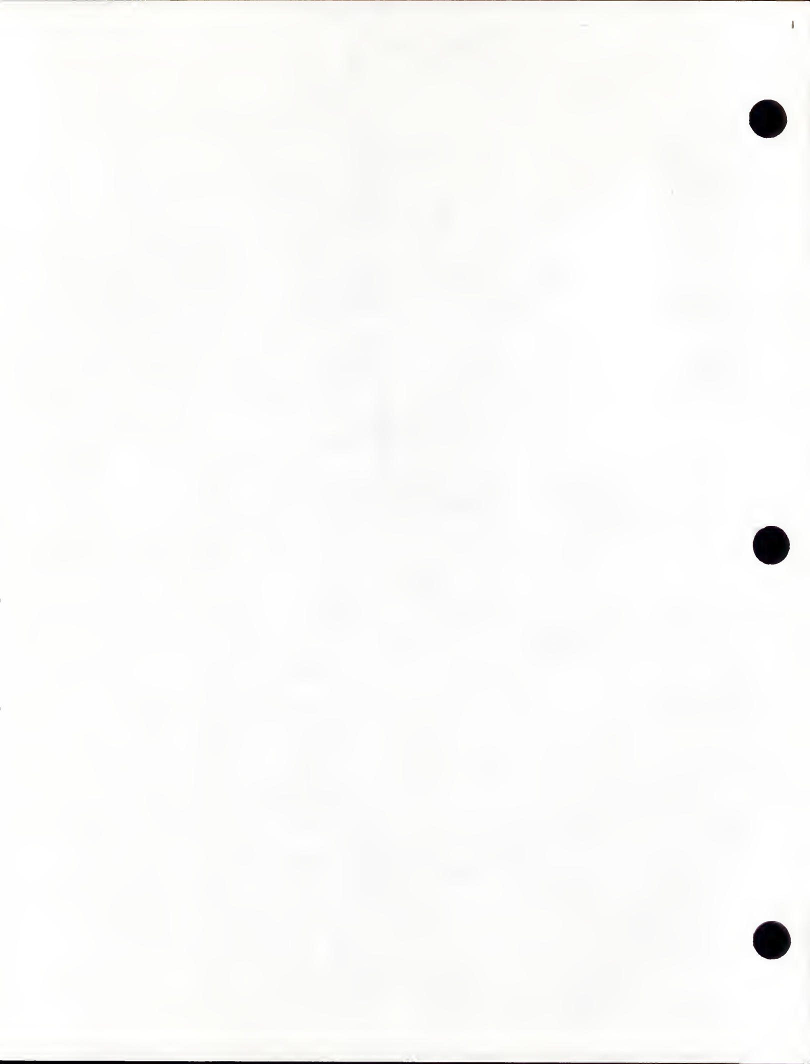
LEGISLATION ENACTED SINCE 1980 WITH MAJOR IMPACT ON MEDICARE AND MEDICAID

	Title	Enactment
1.	The Omnibus Reconciliation Act	1980
2.	The Tax Equity and Fiscal Responsibility Act	1982
3.	The Social Security Amendments of 1983	1983
4.	The Deficit Reduction Act	1984
5.	The Balanced Budget Act	1985
6.	The Consolidated Omnibus Budget Reconciliation Act	1986
7.	The Omnibus Budget Reconciliation Act of 1986	1986
8.	State Comprehensive Mental Health Plan Act of 1986	1986
9.	The Medicare and Medicaid Patient and Program Protection Act of 1987	1987
10.	The Omnibus Budget Reconciliation Act of 1987	1987
11.	The Medicare Catastrophic Coverage Act of 1988	1988
12.	The Family Support Act of 1988	1988
13.	The Health Maintenance Organization Amendments	1988
14.	The Clinical Laboratory Improvement Amendments of 1988	1988
15.	The Technical and Miscellaneous Revenue Act of 1988	1988
16.	The Medicare Catastrophic Coverage Repeal Act of 1989	1989
17.	The Omnibus Budget Reconciliation Act of 1989	1989
18.	The Omnibus Budget Reconciliation Act of 1990	1990



APPENDIX F

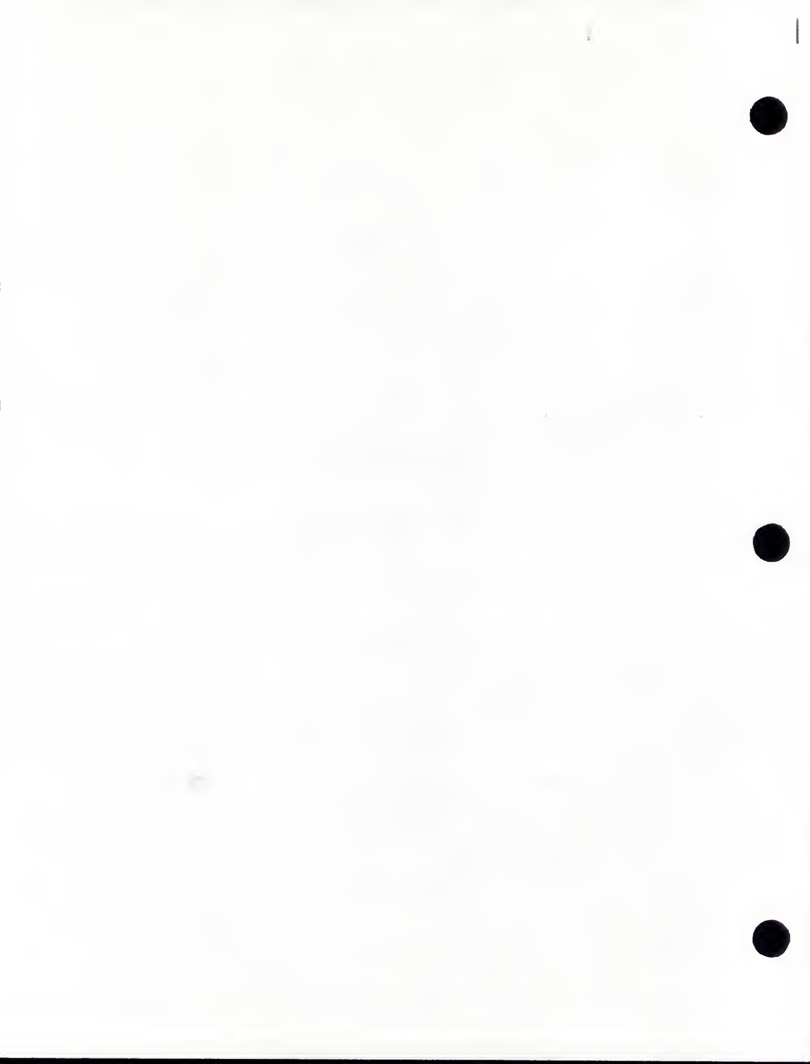
EMPLOYEES IN 12 KEY SERIES: FISCAL YEARS 1984-1990



Number of HCFA Employees in 12 Key Series for FY 1984 - 1990							
	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
101 Series	40	46	49	53	57	68	67
110 Series	15	16	17	14	15	15	19
301 Series	826	847	855	749	739	759	775
334 Series	278	267	254	220	227	236	236
340 Series	62	60	59	76	79	74	77
343 Series	114	113	111	118	123	136	136
345 Series	785	786	767	880	939	1003	1000
501 Series	116	111	108	112	115	109	110
510 Series	242	214	198	180	181	188	178
511 Series	33	60	64	73	72	69	68
601 Series	37	52	55	55	52	54	52
1102 Series	52	45	57	56	54	63	64
TOTALS	2600	2617	2594	2586	2653	2774	2782

APPENDIX G

STAFF/WORKLOAD INDICATORS



STAFF/WORKLOAD INDICATORS

Six survey questions that were asked of all respondents have some value in understanding how HCFA staff feel about the relationship of HCFA staff levels to HCFA work requirements.

Q.31 **My unit has too many staff for the work assigned.**

Percent Disagreement

	Central Office	Regional Office	Total
Supervisors	92	95	93
Non-supervisors	79	85	81

Q. 37 **My unit has enough staff to do the job right and on time.**

Percent Disagreement

	Central Office	Regional Office	Total
Supervisors	69	64	67
Non-supervisors	47	55	50

Q. 39 **I am not given enough work.**

Percent Disagreement

	Central Office	Regional Office	Total
Supervisors	90	95	92
Non-supervisors	77	84	79

Q.35 My workload is excessive.

	Percent Agreement		
	Central Office	Regional Office	Total
Supervisors	67	72	68
Non-supervisors	46	50	48

Q.43 I never seem to have enough time to get the work done.

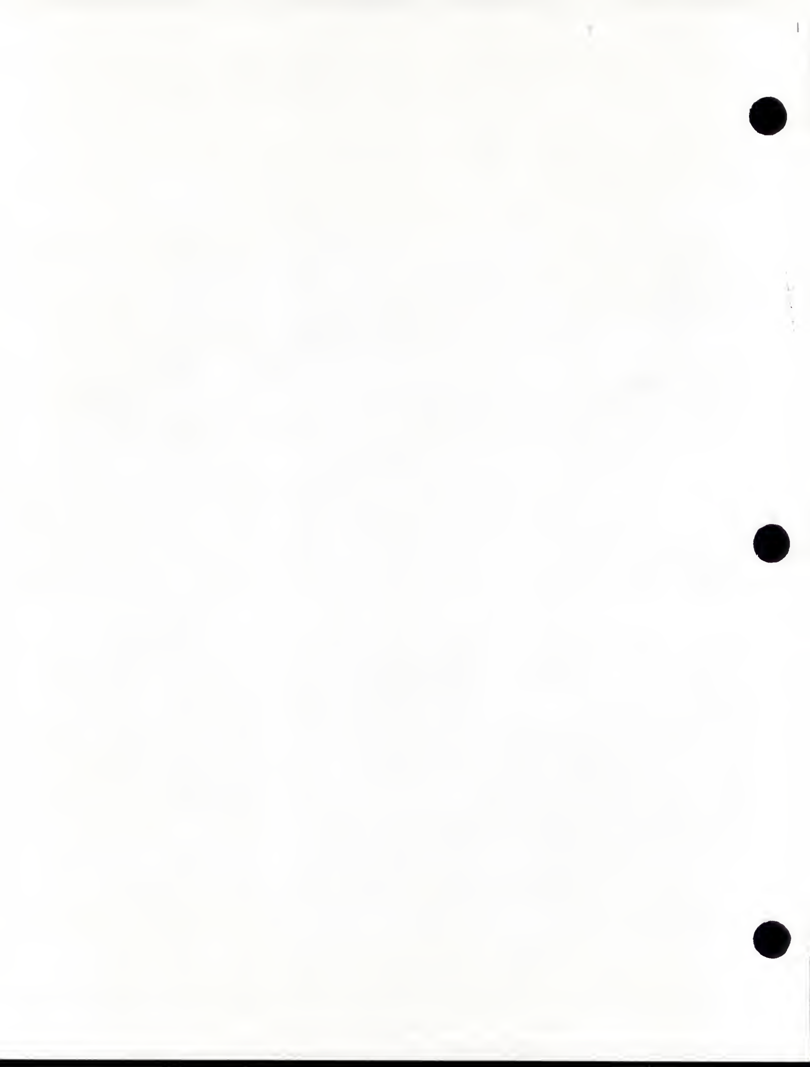
	Percent Agreement		
	Central Office	Regional Office	Total
Supervisors	59	55	58
Non-supervisors	38	43	40

Q.61 How satisfied are you with the amount of stress in your job?

	Percent Dissatisfied		
	Central Office	Regional Office	Total
Supervisors	55	50	53
Non-supervisors	39	41	40

Q. 82 **The number of professional and administrative staff in the unit you supervise is:**

	Percent Responding		
	Central Office	Regional Office	Total
Excessive	3	0	2
About Right	28	32	29
Inadequate	30	31	30
Very Inadequate	39	37	38



APPENDIX H

OHR ORGANIZATION CHART

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

OFFICE OF THE ASSOCIATE ADMINISTRATOR FOR MANAGEMENT

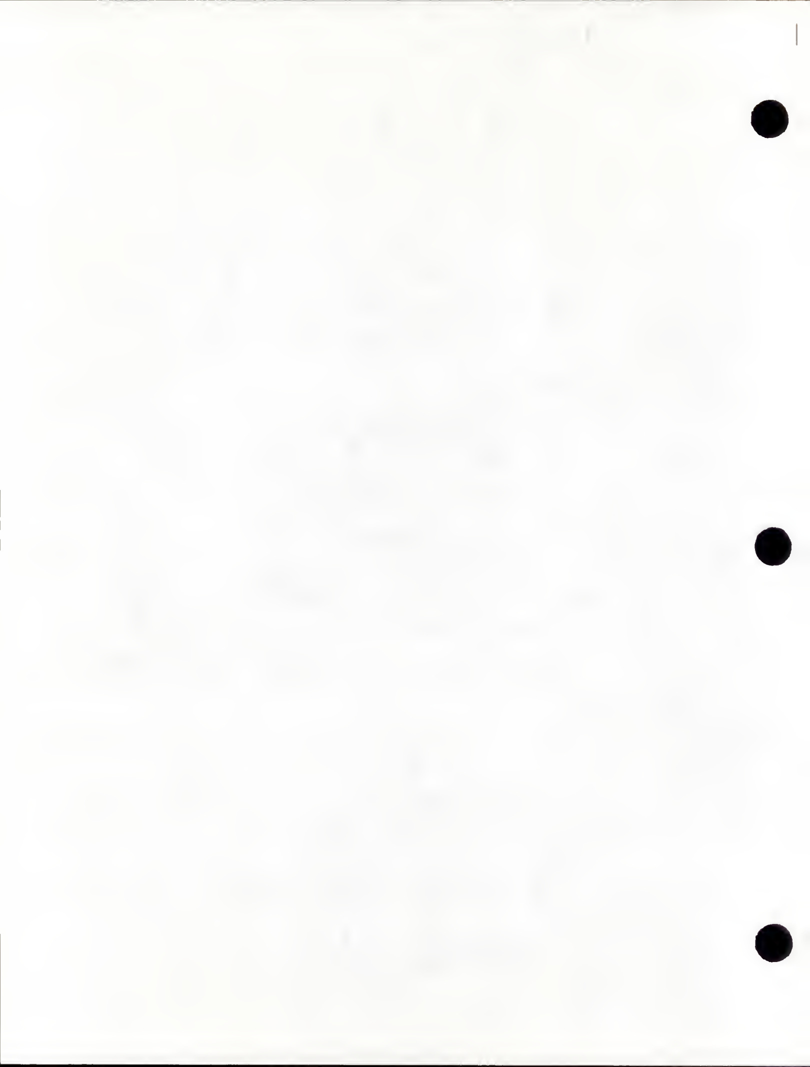
OFFICE OF BUDGET AND ADMINISTRATION

APPROVED STRUCTURE

As of May 14, 1991

OFFICE OF HUMAN RESOURCES

- OFFICE OF HUMAN RESOURCES (2-11-88) FHA6
  - LABOR/MANAGEMENT RELATIONS STAFF (2-11-88) FHA6-1
  - PERSONNEL POLICY AND EVALUATIONS STAFF (3-23-89) FHA6-2
  - DIVISION OF CLASSIFICATION & ORGANIZATIONAL ANALYSIS (2-11-88) FHA61
    - CLASSIFICATION ANALYSIS BRANCH (2-11-88) FHA611
    - ORGANIZATIONAL ANALYSIS BRANCH (2-11-88) FHA612
  - DIVISION OF STAFFING AND EMPLOYEE SERVICES (5-14-91) FHA62
    - STAFFING BRANCH (5-14-91) FHA621
    - EMPLOYEE AND HEALTH SERVICES BRANCH (2-11-88) FHA622
      - EMPLOYEE BENEFITS AND RECORDS SECTION (5-14-91) FHA6221
  - DIVISION OF PERFORMANCE MANAGEMENT AND DEVELOPMENT (5-14-91) FHA63
    - PERFORMANCE MANAGEMENT AND AWARDS BRANCH (5-14-91) FHA631
    - TRAINING AND CAREER DEVELOPMENT BRANCH (2-11-88) FHA633



APPENDIX I

LIST OF PANEL RECOMMENDATIONS

LIST OF PANEL RECOMMENDATIONS

CHAPTER FOUR

The panel recommends that HCFA:

- **Develop and maintain a data base on its staff.** Efforts to develop such a system have been initiated recently and the panel urges that this work be continued on a priority basis. A reliable workforce data system is an essential prerequisite to meaningful workforce planning. (pg. 58)

- **Develop a proactive program to deal with staff performance issues.** These efforts should include increased staff training, placement of inappropriately assigned staff in positions more appropriate to their qualifications and abilities, and taking adverse action where other more positive efforts do not succeed. OHR should develop an action plan to help supervisors and managers deal with staff performance issues. (pg. 58)

- **Develop a long-range human resource planning process.** Such a planning process, which should include senior management evaluation of progress towards accomplishing the resultant HRM plans, is essential to improve HRM in HCFA and to enable it to carry out effectively its growing responsibilities into the next century. (pg. 58)

- **Seek authority to increase its staff levels by modest increments during the next few years as it deals with the issues mentioned in this report.** Increases of up to a total of 10 percent would appear to be reasonable to give HCFA management the resource flexibility to deal effectively with the many issues it must face, including current workload demands and requirements for strengthening the workforce potential. The panel recommends further that the secretary of HHS, the director of OMB, and Congress consider favorably HCFA requests for staff level increases within this range. (pg. 58)

CHAPTER FIVE

The panel recommends that HCFA:

- **Develop and operate a HCFA-wide staffing program based on the human resource plan recommended in Chapter Four.** (pg. 63)

- **As part of its human resources planning process, assess its ability to increase minority and female representation at the management levels through promotion of present mid-level staff.** If it is concluded that problems exist, targeted efforts should be developed to recruit highly qualified minority and female candidates into professional and administrative career ladder positions. This effort should be integrated into the HCFA-wide staffing program recommended in the preceding section of this chapter. (pg. 65)

- **Examine in some detail survey data showing that a high percentage of staff do not believe they are fairly compensated in comparison to other staff doing comparable work and develop a plan to address particular problem areas that may be identified. (pg. 70)**

- **Establish a system to monitor classification decisions to ensure there is classification equity among comparable positions between regions.** When problems are identified, HCFA should work with the appropriate RPOs and issue any managerial guidance needed to the HCFA regional offices. (pg. 71)

- **Proceed to revise the process for the classification of senior, non-supervisory professional and administrative positions in instances where the impact of the person on the job is an issue, to give greater emphasis to senior management participation -- or possibly a peer review involving outside experts -- in the decision process.** Evaluation of the impact of the person on the job requires a management consensus, not one reached solely between the recommending supervisor and the position classification specialist. (pg. 71)

- **Undertake a comprehensive continuing training needs assessment of the entire workforce.** This assessment should examine current and projected staff skill needs. (pg. 77)

- **Establish as a priority a strong and continuing training and career development program that is sheltered from being the first program cut when funds are reduced.** (pg. 77)

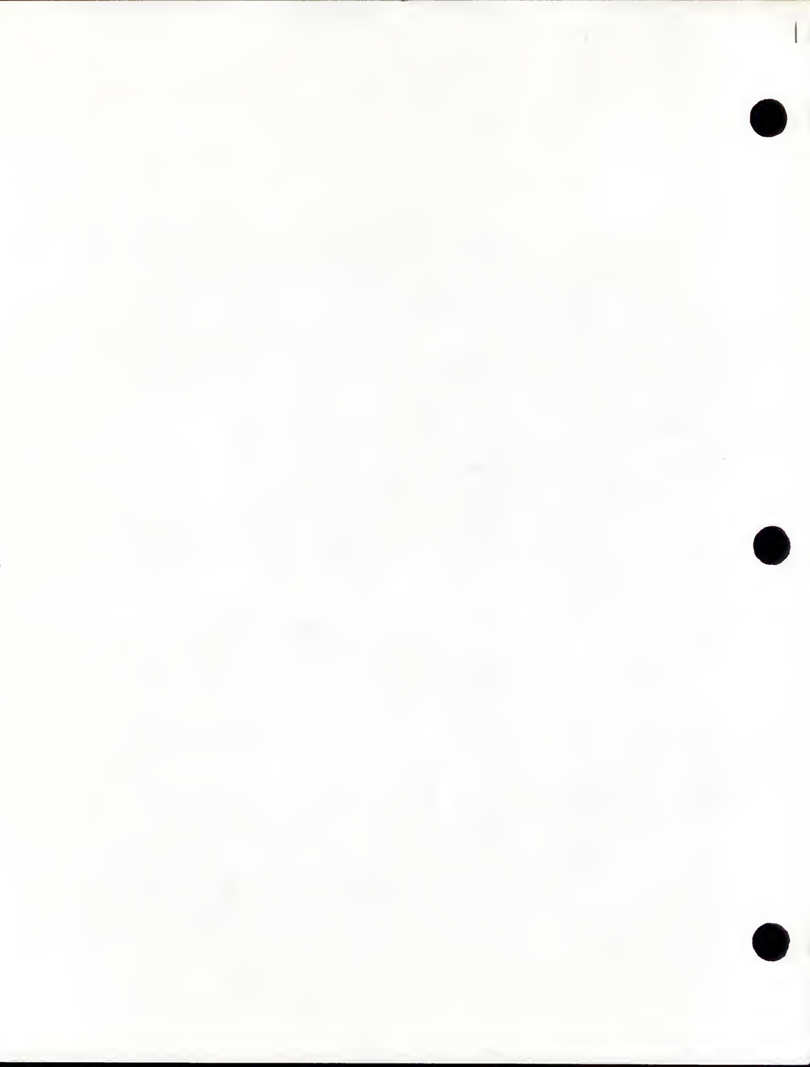
- **Redirect the OHR mission to provide HRM support for the entire agency including support for agency consideration of the long-range strategic HRM issues discussed in this report.** (pg. 80)

CHAPTER SIX

The panel recommends that:

- A senior management official be charged with the responsibility for directing, on behalf of the administrator, the development of strategies and for seeing to their implementation and execution. This official should be a strong leader with a demonstrated record in management and a long-term commitment to the agency. The organizational level at which this responsibility is placed is not as important as clearly establishing within the agency the value to be placed on the HRM function. This can be done only by the administrator through continuing interest in and commitment to the subject. (pg. 83)

- The administrator, as a first step toward institutionalizing leadership attention to human resource issues, establish a task force broadly representative of the organization to consider, in light of this report, specific organizational and functional issues and options for the administrator's consideration. In the panel's view, this approach will result in final decisions that are more likely to enjoy a high degree of organizational acceptance and be more finely tuned to the needs of HCFA, and thus be more likely to survive changes in administration and stand the test of time. (pg. 84)



APPENDIX J

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

September 3, 1991

Mr. Don Wortman
Project Director
National Academy of Public Administration
1120 G Street, NW, Suite 540
Washington, D. C. 20005-3801

Dear Mr. Wortman: Don

I, along with Senior Staff, have reviewed the National Academy of Public Administration's (NAPA) draft report, entitled "An Agency at Risk: An Evaluation of Human Resource Management at the Health Care Financing Administration (HCFA)." Overall, we have no major problems with the report and, in fact, find that the study was extremely perceptive in identifying many problems that we are already aware of and have targeted for corrective action. I was pleased to receive the report prior to this year's Senior Staff retreat held the first week in June. Having this report verify what many of us already believed were problems in the Agency helped steer the retreat agenda to discussion of management's short- and long-term options for resolving these problems. Of course, problems of this magnitude cannot be resolved in a two day discussion. Therefore, we are currently in the process of scheduling a series of senior management planning sessions to continue our discussions of these and other issues critical to the Agency.

A discussion of our comments on the recommendations of the draft report are enclosed. Many of our comments simply bring you up-to-date on corrective actions we have taken in several areas since the start of the NAPA study. Since the final report will be shared with many parties internal and external to the Agency. I would like the final version to reflect our efforts thus far in correcting many of the problems identified in the report.

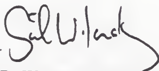
I am pleased with the report and believe it will benefit the Agency in several ways. First, the Department, the Office of Management and Budget, and Congress can and should consider the NAPA report as they review and appropriate funds for our programs. Second, the study findings and recommendations can and will be used internally to improve our operations.

It was a pleasure to meet with you and the NAPA panel on several occasions during the course of the study. I look forward to seeing the final report.

If you have any further issues you wish to discuss, please give me a call. If I am not available, Robert Streimer is available to assist you. NAPA project staff may contact Linda Watson, HCFA's project officer, if they require clarification on any of the enclosed comments. Linda will also work with your staff on the logistics for presentation and distribution of the final report.

Thank you for the opportunity to comment on this report.

Sincerely,



Gail R. Wilensky, Ph.D.
Administrator

Enclosure

Thanks for all your hard work!

Comments to the NAPA Report, Entitled
"An Agency At Risk: An Evaluation of Human Resource Management At HCFA"

The comments are presented based on the order of the recommendations outlined in Appendix I.

Chapter Four, Recommendation 1: Develop and maintain a data base on its staff.

As recommended in the draft report, development of a historical personnel data base has been made one of our systems priorities. Prior to the conduct of the NAPA study, we were in the early stages of developing an employee data base. As we have discovered, developing a comprehensive personnel system to perform short- and long-range Agency analyses is a major, as well as time-consuming, undertaking. Therefore, before we continue to invest a substantial number of additional resources (time and funding) into this effort, and due to the many problems you encountered in obtaining necessary data to conduct your analyses, we want to ensure that the system we have begun to develop will meet our needs.

Therefore, we have recently signed a contract with a computer systems company specializing in administrative systems. The company has been tasked with assessing our current and planned personnel system and will recommend how we should proceed. The contractor estimates that the assessment will be completed in approximately 3 months. HCFA's project officer, Linda Watson, has spoken with your consultant, Greg Ahart, regarding NAPA project staff providing an overview to these contractors outlining the various data problems your staff encountered while conducting the HCFA Personnel Study. Your continued support in assisting us to develop a proficient system is most appreciated.

Chapter Four, Recommendation 2: Develop a proactive program to deal with staff performance issues.

The Associate Administrator for Management has begun work in this area. The first step taken, which occurred while the NAPA study was underway, was to streamline the performance functions in the Agency. In addition, we have begun an intensive training program for OHR employees assigned to this function. We will now begin working with Agency line managers to develop a proactive performance program.

Chapter Four, Recommendation 3: Develop a long-range human resource planning process.

Clarification on all the recommendations dealing with the human resource management program is needed. Throughout the report, the theme of centralization is alluded to but never addressed directly. Is it the view of the panel that local human resource management ought to be reduced/eliminated and in its place a centrally

As mentioned in the comments under Chapter Four, Recommendation 3, we have several questions about this recommendation. We will be discussing this issue with you as part of a possible follow up study.

Chapter Six, Recommendation 1: A senior management official be charged with the responsibility for directing, on behalf of the Administrator, the development of strategies and for seeing to their implementation and execution.

Clarification and further detail on this recommendation is needed. Although we have discussed this issue at length, the report should clearly discuss the panel's perspective on this matter. The recommendation, as written, does not provide the reader with a clear explanation for this recommendation or the associated benefits of such a structure.

Chapter Six, Recommendation 2: The Administrator, as a first step toward institutionalizing leadership attention to human resource issues, establish a task force broadly representative of the organization.

This recommendation will be a major point of discussion among senior management. Our initial reaction would be to have the Directors and senior managers from each of the components participate in this effort.

General Comment:

On page 47 of the report, turnover rates are discussed. The figures are accurate but a more balanced portrayal would also note that the Office of Legislation and Policy has a significantly younger, more mobile work force than HCFA as a whole.

National Academy of Public Administration

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